Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

12523

3 - OUTPATIENT

PATIENTS NAME: [redacted]

[redacted] M.D.

DATE: 7-8-91 AGE: 4

WT: 129 BP:

ALLERGIES:

PCN Codeine

COMPLAINT:

Poison Ivy [redacted]

Dx: Acute Contact Dermatitis

Rx: Depo-Medrol 80 mg

Pen 150 mg

Benadryl 25 mg

MEDS

Cortisone 5 Cream

[redacted]

NAME [redacted] DATE OF BIRTH [redacted]

[redacted] M.D.

DATE: 1-4-95

AGE: 49

WEIGHT: 135

BLOOD PRESSURE: 112/78

COMPLAINT: poison ivy on Chest + arms

ALLERGIES

PCN,

Codeine

MEDS

Cortisone 5 cm

Dx: Severe Contact Dermatitis

Rx: [illegible] 120 I—
may need prednisone [redacted]
[illegible]

000003

NAME [redacted] DATE OF BIRT[redacted]

[redacted], M.D.

DATE: 2-5-96
AGE: 49
WEIGHT: 130½
BLOOD PRESSURE: 120/80
COMPLAINT: Cough, HA, phlegm X2wks
T. 98.3

ALLERGIES
PCN
Codeine
Sulfa

MEDS
Antibiotic
Antihistamine

Chest -) Rhonchi
Throat [illegible]
Imp: [illegible] / [illegible]
Rx: Rocephin 0.5 g
Vantin 200 BID [illegible]
Condal [illegible]

[redacted]

000004

NAME [redacted] DATE OF BIRTH [redacted]

[redacted], M.D.

DATE: 2/11/97

AGE: 49

WEIGHT: 128

BLOOD PRESSURE: 120/68

COMPLAINT: f/u - Still cong., ears cong., HA, nose stopped up

ALLERGIES

PCN

Codeine

Sulfa

MEDS

Vantin

Entex

Ceftin

Chest → Clear

Throat sl red (clear)

Ears → Serous

Imp: Serous / Sinusitis

Plan: [illegible] 100 ...

Sel dose x 3 weeks

Finish Ceftin

[redacted]

000005

NAME [redacted] DATE OF BIRTH [redacted]

[redacted], M.D.

ALLERGIES
codeine
PCN
Sulfa

MEDS
Premarin

DATE: 11-28-95
AGE: 52
WEIGHT: 135 T 96.1
BLOOD PRESSURE: 110/80
COMPLAINT: congestion, febrile x 2 days

Chest → clear

↑ PND

Sinusitis

Rx. Biaxin

Tessalon perles

Deconsal II

Claforan

[redacted]

000006

for [redacted]

AME [redacted] DOB [redacted]

DR. [redacted]

DATE: 8-7-97 COMPLAINT: c/o wt loss, c/o dry cough went to wt loss clinic, still losing wt.

WT: 1?4 P60

AGE: 54

BP: 120/70 all

LMP: Meds: Zoloft Codeine Zithromax

****

HEENT - neg - Had TB skin test

Chest - Clear

Abdo - slight tenderness RUQ

EXT. WNL

Cardiac - A/R 3 (?)

UA → Clear

Rec: UA / CBC / SMAC / serum amylase

Sed rate

1) Chest Xray

2) May need U/S gallbladder

[redacted]

[redacted]

0:45 [redacted] MD

08-07-97

000007

[redacted]

10:45 [redacted] MD

P [redacted] 08-07-97

SEND HOME

PHYSICIAN SIGNATURE _____

DIAGNOSIS	[redacted]	PROC #
		[redacted]

NEW	B/P	INJ. ONLY	LAB ONLY

RETURN	99903 ACCIDENT DATE
_____ Days _____ Wk. _____ Mo. _____ Yr	

M.D. ORDERS:

Authorization to Release Information: I hereby authorize [redacted] to release any information pertaining to my care and treatment necessary for processing insurance claims. Also, I hereby authorize direct payment to [redacted] for all medical surgical expenses incurred. I Understand I am financially responsible for charges not covered by this assignment.

Date: _____ Signed: _____

MEDICARE DISCLOSURE - READ BEFORE SIGNING
I have been advised that _____ may not be covered (indicate line #)
Medicare may not pay because Medicare does not pay for routine tests/services and has limited coverage for some tests/services. I will be responsible to pay for these tests/services if denied by Medicare.

Pt. Signature _____

Witness _____

REASON FOR EXAM:

☐ CALL REPORT STAT

X-RAY REPORT

[redacted] 8/7/97 [redacted]

CHEST TWO VIEWS 8/7/97:

COMMENT: The lungs are clear, normally expanded and the heart and pulmonary vasculature is normal. The visualized soft tissues and skeletal structures are unremarkable.

IMPRESSION:
1) NO ACTIVE DISEASE IN THE CHEST.

[redacted]

[redacted] 8/7/97

[redacted] M. D.

[redacted]

[redacted] ...QUISITION NO. [redacted]

PATIENT [redacted]

Acc # [redacted]

Age: 54 Sex: F [redacted]

Doctor: [redacted]

Received: 08-AUG-97

Reported: 08-AUG-97 [redacted]

Collected: 07-AUG-97 1:25 PM

TEST REQUESTED

LIPASE, ACP, CBCD, SEDRATE, WESTERGREN. [redacted]

Comment: [redacted] Spec/Source: [redacted]

TEST NAME	WITHIN RANGE	OUTSIDE RANGE	REFERENCE RANGE	UNITS
AUTOMATED CHEMISTRY PANEL ************				
GLUCOSE	80		65-125	MG/DL
BUN	10		9-27	MG/DL
CREATININE		0.4 LOW	0.6-1.5	MG/DL
URIC ACID	2.2		2.2-7.7	MG/DL
SODIUM	141		135-147	MEQ/L
POTASSIUM	4.4		3.5-5.3	MEQ/L
CHLORIDE	98		96-109	MEQ/L
PHOSPHORUS	4.5		2.5-4.5	MG/DL
CALCIUM	9.8	[redacted]	8.5-10.6	MG/DL
TOTAL PROTEIN	8.0		6.0-8.5	G/DL
ALBUMIN	4.4		3.5-5.5	G/DL
GLOBULIN	3.6		0.5-4.5	G/DL
TOTAL BILIRUBIN	0.6		0.1-1.2	MG/DL
ALK. PHOS.	65		40-150	IU/L
SGOT(AST)	23		0-45	IU/L
SGPT(ALT)	25		0-50	IU/L
LDH	174		0-240	U/L
GGT	27		0-70	IU/L
IRON	88		40-180	MCG/DL
TRIGLYCERIDE	109		0-199	MG/DL
CHOLESTEROL		224 HIGH [redacted]	0-199	MG/DL
CBC ************				
WBC	5.8	[redacted]	4.0-10.5	THOUS/MM
RBC	4.17		3.80-5.10	MILL/MM
HGB	12.7		11.5-15.0	G/DL
HCT	37.1		34.0-44.0	%
MCV	89		80.0-98.0	FL
MCH	30.5		27.0-34.0	PG
MCHC	34.2		33.5-35.5	%
NEUTROPHILS	58		40-74	%
LYMPHOCYTES	34		14-46	%
MONOCYTES	6		4-13	%
EOSINOPHILS	1		0-7	%
BASOPHILS	1		0-3	%
PLATELET COUNT	310		140-415	THOUS/MM
RDW	12.4		11.7-15.0	%
OTHER TESTS ************				
LIPASE	69		20-190	U/L
SEDRATE, WESTERGREN ************				
WESTERGREN SED RATE		45 HIGH	0-20	MM/HR

Prednisone 1 bid x 4 days then 1 qd x 3 days then ... 7 days

NORMAL SED RATE VALUES INCREASE WITH AGE OF PATIENT.
OVER 50 YRS OF AGE, REFERENCE RANGES FOR MALES WOULD BE
APPROXIMATELY 0 - 20 MM/HR AND FOR FEMALES 0 - 30 MM/HR.

000009

Tests performed by [redacted]

ADDITIONAL OUTPATIENT RECORDS

[redacted]

[redacted]

Patient: [redacted] MR#: [redacted] Date of Exam: 01-18-93

FAMILY PRACTICE

Forty nine year old female in for gyn exam. G2, P2. Hyst in 65 for vaginal bleeding after IUD insertion and appendectomy the same time. No diarrhea, constipation, blood or mucous other complaints. Takes Premarin .625 mg daily.

Past history not remarkable. Parents in good health, sister died from drowning, two children. No family history of breast and colon CA. Does not smoke or drink, rec. drugs. Allergic to Penicillin and Codeine. Last tetanus in 88. ROS, no chest pain, shortness of breath, cough, hemoptysis.

On exam blood pressure 122/80. WT 133. Head normocephalic. TMs' are clear. Sinuses nontender. Nose not congested. Mucous membranes moist. Throat not inflammed. Neck supple without nodes. Chest is clear. Heart regular RR without murmurs or gallops. Breast no masses. No retraction of skin or dimpling. No axillary nodes. Abdomen soft. LIver and spleen and kidney not enlarged. Bowel sounds active without guarding or rebound bruits. Surgical scar. Pelvic normal introitus. Vaginal cuff normal. No adnexal masses. Rectal negative and stool occult blood negative. Extremities normal. Good peripheral pulses.

IMPRESSION. MENOPAUSE.

PLAN. Self breast exam. and schedule mammogram. Premarin .625 daily one month with eleven refills. Followup pending test results.

Cardiac renal profile and [redacted] CBC, pap smear, UA.

Chol 242

[redacted]

Dictating Practitioner: [redacted] MD [redacted]

Reviewed:

000011

[redacted]

Patient: [redacted] MR#: [redacted] Date of Exam: 01-29-93

INTERNAL MEDICINE

This is a 49 year old female who comes in with chief complaint of maxillary area and frontal area pressure and headache, nasal congestion, sore throat, body aches, feverish feeling, cough with expectoration. She has had these symptoms for past five days or so. She is nonsmoker, allergic to Penicillin and Codiene.

PHYSICAL EXAMINATION: Forty-nine year old female. Weight is 132 lbs. Blood pressure is 120/82. Temperature is 100.4. Pulse of 80. Respiratory rate of 16. Ear, nose, throat exam reveals erythemata of the pharynx. TM are clear. Neck is supple without adenopathy. Maxillary area tenderness present. Lungs are clear to auscultation. Heart has regular rate, rhythm without murmurs. Abdomen is soft, nontender. Bowel sounds present.

IMPRESSION: ACUTE SINUSITIS.

PLAN: We will treat her with Bactrim DS 1 p.o.b.i.d. for two weeks. Deconomine SR 1 p.o.b.i.d., lots of fluids. Rest. Followup as needed.

Dictating Practitioner: [redacted] MD [redacted]

Reviewed:

[redacted]

Patient: [redacted] MR#: [redacted] Date of Exam: 02-01-93

INTERNAL MEDICINE

Forty-nine year old female who comes in with chief complaint of sore throat, ear aches, headaches, generalized body aches, was seen on Friday, January 29th, was prescribed Bactrim DS for sinusitis. At that time she had a temperature of 100.4 and she felt nauseous and threw up a couple of times. She has not taken that medications since.

PHYSICAL EXAMINATION: Blood pressure is 116/86. Temperature 99.5. Ear, nose, throat exam reveals mild erythema of the pharynx. Neck is supple without adenopathy. Lungs clear. Heart regular rate, rhythm.

She is allergic to Penicillin and Codiene.

IMPRESSION: SINUSITIS INTOLERANT TO BACTRIM.

PLAN: We will switch her to Ceftin 250 b.i.d. for lots of fluids. Tylenol 2 tablets extrastrength q.4 to 6.h. p.r.n. Followup as needed.

Dictating Practitioner: [redacted]

Reviewed:

[redacted]

Patient: [redacted] MR#: [redacted] Date of Exam: 03/12/93

Triage

CHIEF COMPLAINT: Chest tightness.

HISTORY OF PRESENT ILLNESS: This is a 49-year-old female who comes in with a history of multiple acute medical problems, including recent viral URI. She states that she did a lot more work than usual, including walking 2 miles a day and working more heavily at the post office, her usual occupation, and helping her husband load ammunition last night. She awoke this morning with a slight dryness in the throat which resolved with fluids. She states that after that she began having a chest tightness, stating it really felt like she just was having a hard time in getting air. She states that she had some vague sensory change in the arms and some slight weakness. She did complain of some minimal nausea. In addition, she did have some sweating. She states that she took two Anacin and the symptoms have been improved somewhat with resolving of the diaphoresis, weakness, and nausea. She has no history of smoking cigarettes, family history of cardiac disease, hypertension or any other significant risk factor that I can elicit. She's had no cough or fever.

VITAL SIGNS: Blood pressure 148/96, pulse 85, temperature 97.5.

PHYSICAL EXAMINATION: Tympanic membranes are clear without fluid or retraction. Her throat is pink without tonsillar enlargement or exudates. The lungs are clear without wheezes, rales or rhonchi. The heart is regular rate and rhythm without murmurs, gallops or rubs. The abdomen is soft and nontender. The chest wall is tender over both parasternal costal cartilages with recreation of the patient's chest tightness complaints.

IMPRESSION: COSTOCHONDRITIS.

PLAN: Tolectin 400 mg p.o. t.i.d. for 10 days and followup with primary care. EKG was performed and showed no evidence of acute disease.

Dictating Practitioner: [redacted] MD [redacted]

Reviewed: [redacted]

[redacted]

Patient: [redacted] MR#: [redacted] Date of Exam: 07-27-93

FAMILY PRACTICE

Fifty year old female has a rash on the left elbow. Exposed to poison ivy. Allergic to Penicillin and Codeine.

On exam. blood pressure 120/70. Temp. 98.6. WT 133. The left elbow has a rash.

IMPRESSION. CONTACT DERMATITIS

Lidex E cream bid. Return if no improvment.

Dictating Practitioner: [redacted] MD [redacted]

Reviewed:

000015

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 03/10/94 Page: 1 of 1

Fifty year old female in for gyn exam. Menopausal. G2, P2. Had hyst for IUD and bleeding and appendectomy. Takes Premarin .625 daily and needs refill. Complains of nasal congestion and headache on the right side of the head and neck probably from tension and stress. No TMJ dysfunction. Mammogram 1/94 was normal. ROS negative. No other complaints.

On exam Blood pressure 110/80. Temp. 97.3. WT 137. Well developed and well nourished, in no acute distress. Tm's are clear and sinuses nontender. Throat not inflammed. Neck supple and chest is clear. Heart regular RR without murmur or gallops. Neck has good range of motion. Chest is clear and heart regular rate and rhythm without murmur. Breast no masses, no retraction of skin or dimpling. No nodes. Abdomen soft, liver, spleen and kidney not enlarged. Surgical scar. Bowel sounds active without bruit, guarding or rebound.

Pelvic normal introitus. Vaginal cuff normal and no adnexal masses. Unable to feel the intact ovaries. Rectal and stool occult blood negative.

IMPRESSION: MENOPAUSE.

Refill Premarin .625 daily #100 with one refill. Return for fasting chol. and flex sig. Continue self breast exam. Pap smear not taken because of hyst.

[redacted]

[redacted]

Dictated: 03/10/94
Transcribed: 03/14/94

[redacted]

[redacted]

[redacted]

MAR 10 1994 AGE 50 OCCUPATION: Postal

CC [redacted] [redacted]

(Broke current Rx)

HX:

1. Diabetes ⊖
2. H&P ⊖
3. Other Disorders: ⊖
4. Medication ⊖
5. Allergies PCN & Codeine
6. Glaucoma ⊖
7. Eye Injury ⊖
8. Eye Surgery ⊖
9. Headaches OCC.
10. Glass Rx: From ____ To ____
OTC OD +1.75 DS
OS +1.75 DS

Visual Acuity

	OD	OS
@d		
w/Rx	20/	20/
w/o Rx	20/20-1	20/30-1
@N		
w/Rx	20/60	20/60
w/o Rx	20/200	20/200

External

1. Orbit → ⊘
2. Lids → ⊘
3. EOM intact
4. Pupils PERRLA
5. IOP 11 OD
11 OS

1. Conj. } clear
2. Cornea }
3. Sclera }
4. A/C 4/4 OU
5. Lens clear

Fundus 0.5% O + 0.5% M OU @ 10:35A

1. Vitreous clear
2. Optic disc C/D .1/.1 OU
3. Macula ⊕ FR OU
4. Blood vessels A/V 2/3 OU ⊕ SVP OU
5. Retina flat OU

Positive findings

P.D. 63/60

NPC Nose BI/12 BO 40

Acc Amp. 2cm

Confrontations full OU

Cover Test D ⊘
N 6-8 Δ XP

Subj OD +0.50 DS 20/20
OS +0.75 DS 20/20 20/15

Add +2.00 OU
20/20

W4D ⊘
V ⊘

Diagnosis
Hyperopia
Presbyopia
RN Lx for EE or p.r.n.
[redacted] MD

000017

[redacted]

[redacted]

[redacted]

DATE MAR 10 1994

PRESCRIPTION FOR SPECTACLE LENSES:

	SPH	CYL	AXIS	ADD	PD
OD	+0.50	DS		+2.00	DIST / NEAR
OS	+0.75	DS		+2.00	

INSTRUCTIONS:

SV near only if desired

TO DISPENSER: Upon Acceptance Of This Rx, Dispenser Agrees to Provide Proper Frame Fitting And Adjustments And Lens Power Adjustments If Necessary.

Do Not Accept Otherwise.

[redacted] M.D.

EXPIRES IN ONE YEAR [redacted]

[redacted]

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 03/24/94 Page: 1 of 1

Thirty year old female referred for flex sig. No FH of GI cancer. Has no complaints. Flex sig. risks and complications were discussed and written consent obtained.

PROCEDURE. The patient was placed in the left lateral decubitus position. Blood pressure 118/80. WT 133. Temp. 97.8. Well developed and well nourished, in no acute distress. External rectal reveals hemorrhoid tissue. Internal sphincter tone is good. Flex. sig. was inserted and advanced to 65 cm. There were no signs of diverticulitis, strictures, ulcerations or polyps. Prep was adequate. The scope was withrawn and no abnormalities seen.

IMPRESSION: NORMAL FLEX. SIG. HEMORRHOIDAL TISSUE. MENOPAUSE.

Continue Premarin .625 daily. Return in six months.

[redacted] CBC and chem profile, CV risk.

[redacted]

chol 240
158 LDL

[redacted]

[redacted]

Dictated: 03/24/94
Transcribed: 03/30/94

[redacted]

[redacted]
Reviewed

[redacted]

AFTER HOURS PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 06/24/94 Page: 1 of 1

REASON FOR VISIT: Evaluation of recent insect bite.

HISTORY OF PRESENT ILLNESS: Patient is a 51 year old white female, with a past medical history significant for allergic reactions to wasp bites, who presents for evaluation of rash secondary to recent wasp bite. She denies any pulmonary problems.

PHYSICAL EXAMINATION:
BLOOD PRESSURE: 100/60.
PULSE: 72.
TEMPERATURE: 98.4 degrees.
WEIGHT: 135 lbs.
GENERAL: In no acute distress.
EXTREMITIES: In the medial aspect of her left thigh, there was evidence of an insect bite with progressive area of erythema and hyperthermia, mainly, in the mid-aspect of her thigh. There is no purulent drainage. There was no fluctuation.

IMPRESSION: INSECT BITE, POSSIBLE SECONDARY INFECTION.

TREATMENT: Medrol pack was given. Keflex 250 mg. PO qid. I had a long discussion with the patient. The patient has had significant allergic reactions to insect bites. Therefore, a prescription for Epi-kit was given and the patient will carry that with her.

Dictated by Dr. [redacted]

[redacted]

Dictated: 06/24/94
Transcribed: 06/27/94
[redacted]

[redacted]
Reviewed

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 09/26/94 Page: 1 of 1

HISTORY: Patient is a 51-year old female presents today complaining of one week history of sore throat, sinus drainage, occasional cough. She's allergic to codeine and Penicillin. She has some cough syrup remaining from a previous cold given to her by Dr. [redacted] She presently takes hormones as she's status post hysterectomy. No other problems or complaints voiced today. Remaining review of systems is negative.

PHYSICAL EXAMINATION: Weight 139 lbs, T. 98.4, blood pressure 118/62. HEENT is remarkable for moderate posterior pharyngeal erythema. Neck supple without adenopathy. Lungs are clear. Heart's regular.

PLAN: Dr. [redacted] consulted. Patient placed on Deconamine SR, 1 po BID as needed for congestion. Keflex 250 mg TID x 10 days. She's to increase her rest and fluids and follow-up if she does not note improvement.

DIAGNOSIS: NASOPHARYNGITIS

[redacted]

[redacted]

Dictated: 09/26/94
Transcribed: 09/30/94

[redacted]

[redacted]
Reviewed

000021

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 11/11/94 Page: 1 of 1

Patient is a 51 year old female who presents today for annual pap smear, renewal on her Premarin 0.625 mg daily. Also due for mammogram in January. Had flexible sigmoidoscopy which was normal last March. Also had blood work at that time which showed a cholesterol of 240. She is not fasting today.

On physical examination, weight is 139-1/2; temperature 98.8; blood pressure 120/74. HEENT examination unremarkable. Lungs are clear. Heart regular. Abdomen soft and nontender. Breast exam revealed no palpable masses or tenderness. Pelvic exam performed. Normal introitus. Pap smear obtained. Patient is status post partial hysterectomy. Bimanual examination unremarkable. Rectal examination performed. Stool was guaiac negative.

PLAN
Dr. [redacted] was consulted. Patient's premarin was renewed for the next year. She has been scheduled for routine mammogram and will see her back after the new year fasting so that we can obtain a recheck on the cholesterol. She is to follow up in the meantime, sooner if needed.

DIAGNOSIS: PPB

[redacted]

[redacted]

Dictated: 11/11/94
Transcribed: 11/14/94

[redacted]

11/16/94
ml letter sent

[redacted]

[redacted]

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 02/27/95 Page: 1 of 1

Patient is a fifty-one year old female complaining of tired and fatigue and is often pushing herself. She is sleeping about six hours a day, plus a nap in the afternoon. She is still dozing off, especially when she drives. She is currently taking Premarin .625 mg. daily. She is complaining of occasional constipation despite drinking more water and fiber. Otherwise, no other complaints.

EXAM: Blood pressure is 118/78. Temperature is 98. Weight is 138. Patient is a well-nourished, well-developed female in no apparent distress. Neck supple. Chest clear. Heart is regular sinus rhythm.

IMPRESSION: (1). MENOPAUSE. (2). FATIGUE.

PLAN: Continue Premarin .625 mg. p.o. daily. Repeat the cholesterol test and also a thyroid exam. Return to the office in six months.

CBC, Chem profile II and TSH.

[redacted] Chol 270 37
LDL 198
Glucose then 384 LFT [redacted]
[redacted] R/C [redacted]

[redacted]

Dictated: 02/27/95
Transcribed: 03/02/95
[redacted]

[redacted] Reviewed

000023

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 03/14/95 Page: 1 of 1

Patient is a fifty-one year old female who just came back from a skiing trip on March 11th and injured her left knee when she fell down the slopes. She noticed some swelling and put ice on it. She is able to walk with a limping gait. Her work requires to climb lots of stairs and she request some time off. Otherwise, denies any complaints.

EXAM: Blood pressure is 120/80. Temperature is 98.7. Weight is 140. Patient is a well-nourished, well-developed female in no apparent distress. Noticed sunburn on the forehead area. The extremities reveal there is slight swelling on the suprapatellar area, range of motion is normal although there is some pain with movement. There is tenderness on the medial collateral ligament. The tibial plateau is normal. Negative anterior Drawer sign. No effusion. Neurological examination, reflexes are normal.

X-ray of the knee is negative.

IMPRESSION: (1). STRAINED LEFT KNEE. (2). MENOPAUSE.

PLAN: Continue Premarin .625 mg. daily. Advised massage, elevation, range of motion exercise and Advil p.r.n. for pain. Return to the office in ten days or sooner if condition does not improve, otherwise follow-up in six months for regular checkup.

[redacted]

[redacted]

Dictated: 03/15/95
Transcribed: 03/20/95

[redacted]

[redacted] viewed

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 08/29/95 Page: 1 of 1

Patient is a fifty-two year old female request cholesterol testing. Her last blood test was on February 1995 with cholesterol of 270, LDL 198 and cholesterol HDL ratio of 4.7. She has lost approximately a pound and a half on straight diet control. She also takes her Premarin regularly and previously was seen for the left knee pain and the problem was stable. She has no difficulty ambulating. Otherwise, no other complaints.

EXAM: Blood pressure is 120/78. Weight is 138-1/2. Chest is clear. Heart is regular sinus rhythm.

IMPRESSION: (1). HYPERLIPIDEMIA. (2). MENOPAUSE.

PLAN: Continue Premarin .625 mg. daily and low-fat/low-carbohydrate diet. Return to the office in six months depending on the test results.

CV risk profile. [redacted]

[redacted]

Dictated: 08/30/95
Transcribed: 09/05/95
[redacted]

[redacted]
Reviewed

000025

ADULT HISTORY

SS#: [redacted] | [redacted] | TODAY'S DATE: 8-29-95

NAME (FIRST) (MIDDLE) (LAST): [redacted]

ADDRESS: [redacted]

DATE OF BIRTH [redacted] PHONE

MARITAL STATUS
SINGLE__ MARRIED ✓ SEPARATED__ DIVORCED __

TYPE OF WORK: Clerk — EMPLOYED NOW? YES ✓ NO __
SELF: _____

SPOUSE: Manufacturer — YES ✓ NO __

NOTIFY IN CASE OF EMERGENCY: [redacted]

PHONE [redacted]

PAST MEDICAL HISTORY (GIVE NAMES AND DATES)

PREVIOUS SURGERIES: Hysterectomy 1970

HOSPITALIZATIONS:

MAJOR ILLNESSES OR INJURIES: Knee injury (twice)

FAMILY HISTORY	AGE IF LIVING	AGE AT DEATH	PRESENT CONDITION OR CAUSE OF DEATH
FATHER	78		
MOTHER	74		Good
BROTHERS No. 1	41		Good
SISTERS No. 2	48	45	Drowning
CHILDREN No. 2	31-33		Good

HAS A PARENT, BROTHER, OR SISTER EVER HAD:

ARTHRITIS..... __
ASTHMA..... __
BREAST CANCER ..... __
COLON CANCER..... __
COLON POLYPS..... __
DIABETES..... __
HEART TROUBLE..... __
HIGH BLOOD PRESSURE... __
HIGH CHOLESTEROL..... ✓
STROKE..... __
THYROID TROUBLE..... __
TUBERCULOSIS..... __
STOMACH ULCERS..... __

HAVE YOU EVER SMOKED? NO
YES__ HOW MUCH _____ NO ✓

HAVE YOU EVER USED RECREATIONAL DRUGS?
YES__ HOW MUCH _____ NO ✓

DO YOU DRINK ALCOHOL?
YES ✓ IF YES - HOW MUCH 1-MO 2-MO NO__

PRESENT WEIGHT: 139

PRESENT HEIGHT: 5'2½"

LAST TETANUS? 1994

LIST ALLERGIES TO MEDICATIONS:
Codeine
Penicillin

LIST CURRENT MEDICATIONS:
Premarin

[redacted]

FOR ADDITIONAL INFORMATION USE BACK.

REVIEWED BY:

000026

[redacted]

SS#:	[redacted]	TODAY'S DATE:

NAME (FIRST) (MIDDLE) (LAST)
[redacted]

ADDRESS
[redacted]

DATE OF BIRTH PHONE
[redacted]

MARITAL STATUS
SINGLE__ MARRIED ✓ SEPARATED__ DIVORCED __

TYPE OF WORK:
SELF: Post - [illegible]

EMPLOYED NOW?
YES ✓ NO __

SPOUSE: Self-employed YES ✓ NO __

NOTIFY IN CASE OF EMERGENCY:
[redacted]
PHONE [redacted]

PAST MEDICAL HISTORY (GIVE NAMES AND DATES)

PREVIOUS SURGERIES: 6S Hysterectomy, IUD → bleeding, Hysterectomy C

HOSPITALIZATIONS: Birth, Hysterectomy

MAJOR ILLNESSES OR INJURIES: None G, P. 2

FAMILY HISTORY	AGE IF LIVING	AGE AT DEATH	PRESENT CONDITION OR CAUSE OF DEATH
FATHER	75		[illegible] (Heart problem)
MOTHER	71		
BROTHERS No. 1			Exes
SISTERS No. 1			Is d. drowned
CHILDREN No. 2			Live

HAS A PARENT, BROTHER, OR SISTER EVER HAD:

ARTHRITIS	✓
ASTHMA	__
BREAST CANCER	__
COLON CANCER	__
COLON POLYPS	__
DIABETES	__
HEART TROUBLE	✓
HIGH BLOOD PRESSURE	✓
HIGH CHOLESTEROL	✓
STROKE	✓
THYROID TROUBLE	__
TUBERCULOSIS	__
STOMACH ULCERS	✓

HAVE YOU EVER SMOKED?
YES__ HOW MUCH _____ NO ✓

HAVE YOU EVER USED RECREATIONAL DRUGS?
YES__ HOW MUCH _____ NO ✓

DO YOU DRINK ALCOHOL?
IF YES -
YES__ HOW MUCH _____ NO ✓

PRESENT WEIGHT: 134

PRESENT HEIGHT: 5' 0"

LIST ALLERGIES TO MEDICATIONS:
Penicillin
Codeine

LIST CURRENT MEDICATIONS:
Hormone pills

LAST TETANUS? [illegible]

[redacted]

FOR ADDITIONAL INFORMATION USE BACK.

[redacted]

[redacted] 000027

B L E M L I S T | M (F) | B (W) O | ADULT SICKLE CELL TEST: POS/NEG

LERGIES: Penicillin rash

VERSE/INTOLERANT: codeine) itchy Bactrim GI upset

IMMUNIZATIONS	DATE	DATE	DATE	OTHER IMMUNIZATIONS	DATE	DATE	DATE
ADULT dT	88						
INFLUENZA VAC.	1078)			Pneumvac	1078)		

DATE	HEALTH PROBLEMS	DATE	HEALTH PROBLEMS
	Menopause)		
	Hyperlipidemia chol 270		
	Pneumonia		
			SURGERIES
			appendectomy
		65	Hysterectomy — (no bleeding)
			HOSPITALIZATIONS C-sec,
			RISK FACTORS
			NO TOB
			000028

	1ST	2ND
PKU	NORM/ABN	NORM/ABN
THYROID	NORM/ABN	NORM/ABN
GALACTOSEMIA	NORM/ABN	NORM/ABN
CAH (Adrenal Hyperplasia)	NORM/ABN	NORM/ABN
Sickle Cell	NEG/POS	NEG/POS

[redacted]

[redacted]

[redacted]

TESTS/PROCEDURES FLOW SHEET

PROCEDURE	DATE	REMARKS	DATE	REMARKS
Flex Sig	3 20 94	neg [illegible]		

PATIENT LABEL

000029

[redacted]

DATE	INTERACTION DOCUMENTATION

NAME [redacted] MR.# [redacted] PHONE [redacted]
RX Premarin .625 [redacted]
[redacted] DATE 5-30-96 DR. [redacted]
ROUTE/SITE DATE/TIME Called in SIGNATURE
[redacted] 4-19-96
30-007

NAME [redacted] MR.# [redacted] PHONE
RX Premarin 0.625 mg #90 x3R PHARMACY [redacted]
ROUTE/SITE DATE 7-25-96 DR. [redacted]
[redacted] DATE/TIME Called in SIGNATURE [redacted]
30-007

DATE	INTERACTION DOCUMENTATION
7/31/97	PPD 0.1cc [redacted]
8/1/97	12:30p. PPD 0.1cc ID given (R) forearm per order of Dr [redacted] get MA3
10-7-97	Flu vac 0.5cc IM [redacted]
	Pneumovac 0.5cc IM
10-7-97	5:15 pm Flu Vaccine 0.5cc IM given (R) Deltoid and Pneumovac 0.5cc IM given (L) Deltoid per dr. [redacted]

000030

[redacted]

DATE	INTERACTION DOCUMENTATION
10-18-93	4:49 pm Flu Vax 0.5cc i.m. (L) deltoid per standing order Dr. [redacted]

NAME [redacted] MR.# [redacted] PHONE
RX DT .5cc IM (R) deltoid PHARMACY
DATE 7:35pm DR. [redacted]
ROUTE/SITE IM DATE/TIME 6-24-94 SIGNATURE [redacted]

10/14/94	5:15 Fluvax 0.5cc IM given in (L) deltoid per standing order Dr. [redacted]

NAME [redacted] MR.# [redacted] PHONE
RX Premarin 0.625 mg PHARMACY [redacted]
DATE 11/29/94 DR. [redacted]
ROUTE/SITE [redacted] DATE/TIME 11/30/94 10:38 SIGNATURE [redacted]

NAME [redacted] MR.# [redacted] PHONE
RX Premarin 0.625 mg [redacted] /15/94 PHARMACY [redacted]
DATE 10/1[redacted] DR. [redacted]
ROUTE/SITE [redacted] DATE/TIME [redacted]/94 8:11A SIGNATURE [redacted]

NAME [redacted] MR.# [redacted] PHONE [redacted]
RX Premarin .625 mg #30 DATE 1/4/95 PHARMACY [redacted]
ROUTE/SITE [redacted] DATE/TIME 11/30/94 SIGNATURE [redacted] DR. [redacted]

NAME [redacted] MR.# [redacted] PHONE
RX Kenalog crm 0.1% q.i.d. PHARMACY [redacted]
+ IR DATE 5/22/95
ROUTE/SITE [redacted] DATE/TIME 5/22/95 2:46P SIGNATURE [redacted]

NAME [redacted] MR.# [redacted] PHONE [redacted]
RX Premarin .625 po q d #30
DATE 4-25-96
ROUTE/SITE DATE/TIME called in SIGNATURE [redacted]

30

000031

7-14-97	Kenalog 60 mg IM [redacted]
7/14/97	11:55 Am Kenalog 60 mg given
im (R) dorso-gluteal per Dr	[redacted]

[redacted]

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 01/22/96 Page: 1 of 1

Patient is a fifty-three year old female with history of allergies and mild nasal congestion, but actually on further questioning, she has been having sore throat and fever about a week ago and now developed persistent cough and sinus tenderness. Otherwise, no other complaints.

HISTORY OF ALLERGY TO PENICILLIN AND CODEINE.

EXAM: Blood pressure is 114/74. Temperature is 97.4. Weight is 138. Both TM's are clear. Sinuses slightly tender. Nose is congested. Mouth mucus membranes moist. Throat is slightly inflamed. Neck supple. Chest clear. Heart is regular sinus rhythm.

IMPRESSION: SINUSITIS.

PLAN: Vibramycin 100 mg. p.o. b.i.d. for ten days, to take with food to prevent GI upset and Entex LA b.i.d. for ten days. Return to the office in ten days or sooner if condition does not improve.

[redacted]

[redacted]

Dictated: 01/22/96
Transcribed: 01/23/96

[redacted]

[redacted]

000032

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 04/08/96 Page: 1 of 1

Patient is a fifty-two year old female complaining of being sick for one week with urgency and polyuria and tenderness in the bladder, especially at the end of urination, some CVA tenderness. No fever and chills. She is menopausal. She is currently taking Premarin .625 mg. daily. Otherwise, no other complaints. ALLERGIC TO SULFA, PENICILLIN AND BACTRIM.

REVIEW OF SYSTEMS: Negative.

EXAM: Blood pressure is 130/82. Weight 140. Temperature is 100. Patient is in no apparent distress. Neck supple. Chest is clear. Heart is regular sinus rhythm. Abdomen soft, no liver, spleen or kidney palpable, bowel sounds active, no scars. Pelvic: Normal introitus. Vaginal cuff is normal. No adnexal mass. Breasts: No mass, no retraction or skin dimpling, no lymph node. Back: No CVA tenderness. Extremities normal.

Urinalysis shows WBC 15-20, moderate amount of esterase.

IMPRESSION:
1. URINARY TRACT INFECTION.
2. GYN EXAMINATION AND MENOPAUSE.
3. HYPERLIPIDEMIA.

PLAN: Continue diet, low-fat/low-carbohydrate. Start Keflex 500 mg. 1 p.o. t.i.d. for ten days. Refill Premarin .625 daily and continue monthly self-breast exam. Schedule for mammography.

[redacted]and occult blood test.

[redacted]in the office in ten days or sooner if condition does not [redacted]therwise for yearly check.

[redacted]

[redacted]

Dictated: 04/08/96
Transcribed: 04/10/96

[redacted]

[redacted]

000033

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 03/03/97 Page: 1 of 1

VITAL SIGNS: Blood pressure: 122/70. Weight: 120.5 lbs.

HISTORY:
This patient is a 53 year old Caucasian lady who comes in today stating that she is under a lot of stress. She has had a lot of stress at work. Initially she was trying to lose weight but now it has become easier because she feels the stress is severe. She works at the post office and states that they are changing her duties and have more strenuous work for her. She does not really want to retire because she has worked there for a long time. I have offered to give her a Psych referral for stress management and she would like that.

EXAMINATION:
The patient's thyroid is without nodules or enlargement.

DIAGNOSIS:
1. Stress.

PLAN:
1. The patient is being referred to Psychiatry.
2. Follow-up with me will be on a prn basis.

[redacted]

[redacted]

Dictated: 03/03/97
Transcribed: 03/04/97

[redacted]

[redacted]

Re[redacted]

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 07/14/97 Page: 1 of 1

HISTORY OF PRESENT ILLNESS: The patient is a 54-years-old White female, seen as a walk-in complaining of swelling of the left ankle since July 11, 1997 i.e. three days ago, when she sustained a bee sting to that area.

PAST MEDICAL HISTORY: The patient's past medical history is negative except for hyperlipidemia, and menopause - maintained on Premarin.

ALLERGIES: The patient is allergic to Penicillin and Codeine, as well Bactrim Double Strength.

PHYSICAL EXAMINATION: General appearance: Revealed the patient is in good general condition. Vital signs: Temperature 98.0 degrees. Blood pressure is 132/86. Weight is 121 pounds. Examination - the left ankle showed swelling and there is an area of erythema and mild edema point wise in the dorsolateral aspect of the left ankle area of the bee sting. The edema extend to the dorsal aspect of the left foot. Range of motion of the foot and toes are normal.

IMPRESSION: THE PATIENT SUFFERS FROM ALLERGIC REACTION TO BEE STING.

PLAN:

1. The patient is started on elevation of the foot. Local application of cold. Kenalog 60 mg IM given.

2. Started on Benadryl at bedtime.

3. Patient will call prn. Call for recheck prn.

No other problems discussed in this visit.

DIAGNOSIS: ALLERGIC REACTION TO BEE STING, LEFT ANKLE TO BE FOLLOWED. [redacted]

[redacted]

Dictated: 07/14/97
Transcribed: 07/16/97
[redacted]

[redacted]
Reviewed

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 07/28/97 Page: 1 of 1

Patient is a fifty-four year old complaining of mild nasal congestion for about four days with slight coughing and wheezing with low-grade fever. She denies any chest pain or sinus tenderness or hearing loss.

She was treated about a week ago for yellow jacket bite to the left ankle with steroid injection with improvement.

She had joined a weight watchers group and had taken Mahaung from November until yesterday. She stopped the medication because her friend told her that the medicine may cause heart disease. She lost approximately 24 lbs. since April of 1996. She otherwise denies any other complaints.

EXAM: BP is 122/78. WT is 116. T 97. Both TM's are clear. Sinuses not tender. Nose is slightly congested. Mouth mucus membranes moist. Throat is slightly inflamed. Neck is supple. Chest is clear. Heart is regular sinus rhythm.

IMPRESSION:
1. BRONCHITIS.

PLAN: E-mycin 333 p.o. t.i.d. for ten days, Tessalon Perles every four hours p.r.n. for cough, 4 oz. Advised to follow-up in the office for fasting cholesterol testing in one to two weeks.

[redacted]

[redacted]

Dictated: 07/28/97
Transcribed: 07/29/97

[redacted]

[redacted]

Reviewed

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 08/01/97

Patient is a fifty-four year old female for follow-up. She was seen in the office about three days ago for bronchitis, treated with Tessalon Perles and E-mycin. Medication however caused a little slight diarrhea and abdominal cramps. She still has persistent cough, dry and nonproductive. No fever and chills or chest pain or shortness of breath. She is unable to tolerate Codeine because of itching and Penicillin because of rash.

CURRENT MEDICATIONS: Premarin .625 mg. p.o. q daily.

EXAM: BP is 160/80. WT is 117. T is 97.5. HEENT is negative. Neck supple. Chest has slight rhonchi in the right base. Heart is regular sinus rhythm, no murmurs, gallops or friction rub.

Chest x-ray shows questionable infiltrate in the right base.

IMPRESSION:
1. MENOPAUSE.
2. HYPERLIPIDEMIA.
3. POSSIBLE PNEUMONITIS.

PLAN: Continue medication above. Increase Tessalon Perles to 1 to 2 every six hours. Dextromethorphan for cough.

PPD. Follow-up in the office in one week.

[redacted]

[redacted]

Dictated: 08/02/97
Transcribed: 08/04/97

[redacted]

[redacted] eviewed

[redacted]

AFTER HOURS PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 08/03/97

PROBLEM: 1. Pneumonia. 2. Fatigue. 3. Menopausal syndrome.

SUBJECTIVE: This 54 year old white female is in for follow-up. States she is not improving as much as she would like to on the Ery-Tab 333 1 t.i.d. prescribed by Dr. [redacted] this last Friday approximately three days ago. States that she was told she had pneumonia and was also prescribed Tessalon Perles since she is allergic to Codeine and cannot take the Codeine syrup. She is also allergic to penicillin and Sulfa. Patient notes a continuation of the cough, which is productive of a thick, yellow sputum. She also notes occasional intermittent SOB and anterior chest pain moreso on the right than the left. She is also complaining of some generalized weakness. Denies any temp elevation, night sweats or chills. Patient also notes a 30 lb. weight loss since 11-96; most of this has been intentional. Does note a recent 5 lb. weight loss in the last week or so that has been unintentional. Patient notes that she is scheduled for a mammogram and has a follow-up with Dr. [redacted] in the next few days. ROSS negative.

OBJECTIVE:
Well developed, well nourished, middle-aged white female in no acute distress. Alert and oriented times three. WEIGHT: 116. BLOOD PRESSURE: 144/100. TEMPERATURE: 98.8. RESPIRATIONS: 16. PULSE: 76 and regular. Does not appear dyspneic. Auscultation of the lungs reveal a few rhonchi over the right lung field. No wheezes or rales are noted. Appears somewhat fatigued. Remainder of physical unremarkable.

Chest x-ray obtained today reveals infiltrates on the right. No effusions noted.

CBC reveals a white count of 10700, 74 segs, 1 baso, 23 lymphs, 2 monos, hemoglobin 12.7, hematocrit 38.7.

UA WNL.

Please see earlier dictations.

ASSESSMENT: AS ABOVE.

PLAN: Rocephin 1 gm. with Xylocaine IM now. Switch from Ery-Tab 333 to Z-pack to take as directed. Humibid LA two tablets b.i.d. Obtain chem 1 profile today. Be sure to follow-up with Dr. [redacted] next week. Rest as much as possible. Attend after hours or ER as needed. For Dr. [redacted] and Dr. [redacted]

[redacted]

[redacted]

AFTER HOURS PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 08/03/97 Page: 2 of 2

[redacted]

Dictated: 08/03/97
Transcribed: 08/06/97
[redacted]

[redacted]
Reviewed

000039

[redacted]

PROGRESS NOTE

Patient Name: [redacted]

MedRec#: [redacted]

Date of Exam: 08/14/97

Patient is a fifty-four year old female, who is status post pneumonia. She was treated on July 28th with Erythromycin and Tessalon Perles and on August 3rd was given Rocephin and Zithromax. Her fever and cough is improved, however, she has continued to lose weight. She stopped taking her diet pills, which consist of Ma-huang and noticed improvement and the weight has stabilized about 116. She stopped the diet pills in July. Since her episode of pneumonia, she has been experiencing diarrhea about four times a day with occasional abdominal cramps. She saw an outside physician, Dr. [redacted] and the lab tests were normal. She was given Ambien for sleep. She denies any headache, chills or fever, but just still feels exhausted and weak. She request excuse from work under FMLA.

EXAM: BP is 122/84. WT is 116. Neck supple. Chest is clear. Heart is regular sinus rhythm. Abdomen soft, no liver, spleen or kidney palpable, bowel sounds active, no bruit, guarding or rebound.

IMPRESSION:
1. RESOLVING PNEUMONIA.
2. DIARRHEA, POSSIBLY SECONDARY TO THE INFECTION.

PLAN: Start Metamucil b.i.d. and Amitriptyline 10 mg. 1 to 2 p.o. q 6 P.M. for insomnia. She is to return to the office in one week for repeat chest x-ray.

[redacted]

Chem Profile, CBC, thyroid, TSH, urinalysis, urine for legionnaires titer and stool for clostridium difficile assay.

[redacted]

[redacted]

[redacted]

Dictated: 08/15/97
Transcribed: 08/18/97

[redacted]

[redacted] Reviewed

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 08/20/97 Page: 1 of 1

Patient is a fifty-four year old female for follow-up on pneumonitis. She gained approximately three pounds with increased appetite. She has no cough, fever or chills. Her diarrhea is improved with Flagyl. Previous blood test of legionnaires disease was negative. Stool for clostridium was negative. She otherwise denies any other complaints.

EXAMINATION: Reveals BP is 108/78. WT is 119. HEENT is negative. Neck supple. Chest is clear. Heart is regular sinus rhythm.

Chest x-ray shows slight scoliosis, but no infiltrate.

IMPRESSION:
1. RESOLVING PNEUMONIA.

PLAN: May return to work on August 26th. She is to follow-up in the office in one month.

[redacted]

[redacted]

Dictated: 08/20/97
Transcribed: 08/21/97

[redacted]

[redacted] Reviewed

[redacted]

AFTER HOURS PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 09/17/97

Patient is a fifty-four year old female complaining of hemoptysis. She had a sore throat for approximately ten days with gradual improvement, however, the cough has persist and now today, she coughed up some blood. She has been back to work after a bout of pneumonia for approximately one month.

SHE IS ALLERGIC TO PENICILLIN, SULFA, AND CODEINE.

EXAM: BP is 150/80. WT is 121. T is 97.5. Both TM's are clear. Sinuses not tender. Throat is not inflamed. Neck supple. Chest is clear. Heart is regular sinus rhythm.

IMPRESSION: BRONCHITIS.

PLAN: Vibramycin 100 mg. p.o. b.i.d., Tessalon Perles every four hours p.r.n. for cough. Follow-up in the office in one week or sooner if condition does not improve.

[redacted]

[redacted]

Dictated: 09/17/97
Transcribed: 09/18/97

[redacted]

[redacted] Reviewed

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 10/07/97 Page: 1 of 1

Patient is a fifty-four year old female for follow-up on pneumonia. The problem is completely resolved. The diarrhea has subsided. She has previously taken over-the-counter diet herbal medication and is concerned about the effect on her heart. She denies any chest pain, but has noticed a slight shortness of breath and recently noticed a little flutter sensation. She feels like the chest is giving out on her. She denies any exertional discomfort. She managed to gain 6 lbs. since August. She denies any cough, fever and chills or other pain.

EXAMINATION: Reveals blood pressure is 110/74. WT is 123-1/2. HEENT is negative. Neck supple. Chest is clear. Heart is regular sinus rhythm, no murmurs, gallops or friction rub. Abdomen soft, no liver, spleen or kidney palpable.

IMPRESSION:
1. STATUS POST PNEUMONIA.
2. MENOPAUSE.
3. HYPERLIPIDEMIA.

PLAN: Continue Premarin .625 mg. p.o. daily and observe. She is to return to the office for follow-up in three to six months. Recommended that since no heart murmur was noted, then echocardiogram was not necessary at this point.

Influenza vaccine and Pneumovax.

[redacted]

[redacted]

Dictated: 10/08/97
Transcribed: 10/09/97

[redacted]

[redacted] Reviewed

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 10/21/97

DATE OF EXAM: 10/21/97

CLINICAL HISTORY:
This is a 54 year-old GII PII who presents for annual exam. Patient is postmenopausal and underwent hysterectomy at age 27 for abnormal bleeding. She has no complaints.

PAST MEDICAL HISTORY:
Menopause. Hyperlipidemia. Pneumonia.

PAST SURGICAL HISTORY:
Appendectomy. Hysterectomy 1965.

SOCIAL HISTORY:
Negative for tobacco, alcohol or drug use.

FAMILY HISTORY:
Father with heart disease. Is also positive for arthritis, high blood pressure, stroke, and high cholesterol.

MEDICATIONS:
Premarin 0.625 mg daily.

ALLERGIES:
Penicillin, Bactrim, codeine, and prednisone.

PHYSICAL EXAMINATION:
Blood pressure 130/80. Weight 126-3/4 pounds. This is a well developed, well nourished female in no apparent distress. HEENT: clear. NECK: without thyromegaly. LUNGS: clear to auscultation. HEART: regular rate and rhythm without murmurs, rubs, or gallops. BREASTS: without palpable masses, skin retractions, nipple discharge, or drainage and there is no axillary adenopathy noted. Self breast examination teaching is performed. Breasts examined in the supine and upright position. ABDOMEN: soft, nontender with no organomegaly. BACK: without CVA tenderness. EXTREMITIES: normal. PELVIC: normal external genitalia. Vagina is pink and moist, slight decrease in rugae noted. No significant cystocele or rectocele noted. Cuff is well healed without lesions. On bimanual examination no palpable masses, no adnexal masses, and nontender. RECTAL: normal sphincter tone, no masses and stool is guaiac negative.

(CONTINUED)

[redacted]

PROGRESS NOTE

Patient Name: [redacted] MedRec#: [redacted]

Date of Exam: 10/21/97

ASSESSMENT:
This is a 54 year-old postmenopausal female, normal exam, no complaints. Mammogram performed 10/09/97 no evidence of malignancy.

PLAN:
Pap smear was performed today. Patient is to continue monthly self breast examination, annual Well Woman examinations and she is provided with a refill for Premarin 0.625 mg daily, three month supply for mail order and counseled on calcium 500 mg a day.

[redacted]

[redacted]

Dictated: 10/21/97
Transcribed: 10/27/97

[redacted]

[redacted]

Reviewed

[redacted]

Name: [redacted]
Location:
Doctor:
Patient ID:

Date Collected 1/18/93
Date Received 1/18/93
Report Printed 1/20/93

Specimen #: [redacted] Reviewed by Status: FINAL Age 49 Sex Female

Test Name		Result		Reference Values		Units
49 F						
[redacted] CHEMISTRY PROF						
01 GLUCOSE		89.00		70.00	125.00	MG/DL
02 URIC ACID	L	2.10		2.20	7.70	MG/DL
03 CALCIUM		10.00		8.50	11.00	MG/DL
04 PHOSPHORUS, SERUM		3.60		2.50	4.70	MG/DL
05 CHOLESTEROL, TOTAL	H	242.00		120.00	200.00	MG/DL
06 TRIGLYCERIDES		88.00		30.00	190.00	MG/DL
07 TOTAL PROTEIN		7.40		6.00	8.50	GM/DL
08 ALBUMIN		4.30		3.00	5.50	GM/DL
09 TOTAL GLOBULIN		3.10		1.30	4.20	GM/DL
10 A/G RATIO		1.40		0.70	4.30	
11 BUN		10.00		7.00	26.00	MG/DL
12 CREATININE, SERUM		0.70		0.60	1.50	MG/DL
13 BUN/CREATININE RATIO		14.30		0.00-	0.00	
14 SODIUM, SERUM		141.00		136.00	149.00	MEQ/L
15 POTASSIUM, SERUM		4.30		3.50	5.20	MEQ/L
16 CHLORIDE, SERUM		100.00		96.00	110.00	MEQ/L
17 ALKALINE PHOSPHATASE		33.00		30.00	140.00	U/L
18 BILIRUBIN, TOTAL		0.80		0.20	1.50	MG/DL
19 SGOT		16.00		0.00-	50.00	U/L
20 SGPT		16.00		0.00-	55.00	U/L
21 GGT		11.00		4.00	63.00	U/L
22 IONIZED CALCIUM		5.70		4.00	6.00	MG/DL
23 OSMOLALITY		291.00		266.00	326.00	MOSM/KG

*CHOLESTEROL RECOMMENDATIONS:
NORMAL: LESS THAN 200 MG/DL
BORDERLINE: 200-239 MG/DL
ELEVATED: GREATER THAN 240 MG/DL

CARDIAC/RENAL PROFILE						
01 GLUCOSE		89.00		70.00	125.00	MG/DL
02 URIC ACID	L	2.10		2.20	7.70	MG/DL
03 CHOLESTEROL, TOTAL	H	242.00		120.00	200.00	MG/DL
04 BUN		10.00		7.00	26.00	MG/DL

ACTION TAKEN

Patient Informed by: [X] Mail [ ] Phone [ ] Office visit
Results Were: [ ] Normal [ ] Stable [X] Recheck in 2 months

[ ] Other chart
Reviewed by: [redacted] Date: 1-23-93

[redacted]

Name: [redacted]
Location:
Doctor:
Patient ID:

Date Collected 1/18/93
Date Received 1/18/93
Report Printed 1/20/93

Specimen #: [redacted] Reviewed by Status: FINAL Age 49 Sex Female

Test	Name	Result	Reference Values		Units
05	CREATININE, SERUM	0.70	0.60	1.50	MG/DL
06	BUN/CREATININE RATIO	14.30	0.00-	0.00	
07	SODIUM, SERUM	141.00	136.00	149.00	MEQ/L
08	POTASSIUM, SERUM	4.30	3.50	5.20	MEQ/L
09	CHLORIDE, SERUM	100.00	96.00	110.00	MEQ/L
10	SGOT	16.00	0.00-	50.00	U/L

[redacted]

[redacted]

Name: [redacted]
Location:
Doctor:
Patient ID:

Date Collected 1/18/93
Date Received 1/18/93
Report Printed 1/21/93

Age 49
Specimen #: [redacted] Reviewed by Status: FINAL Sex Female

Test Name	Result	Reference Values	Units
HYST. PAP SCREEN 1 SLIDE			
01 STATEMENT OF ADEQUACY	SATISFACTORY FOR EVALUATION		
04 GENERAL CATEGORIZATION	WITHIN NORMAL LIMITS (M-00120)		
10 RECOMMENDATIONS CLINICALLY INDICATED	SUGGEST REPEAT IN 12 MONTHS, OR AS		
17	[redacted]		

ACTION TAKEN

Patient Informed by: [x] Mail [ ] Phone [ ] Office visit
Results Were: [x] Normal [ ] Stable [ ] Recheck in ___ months

[ ] Other _____

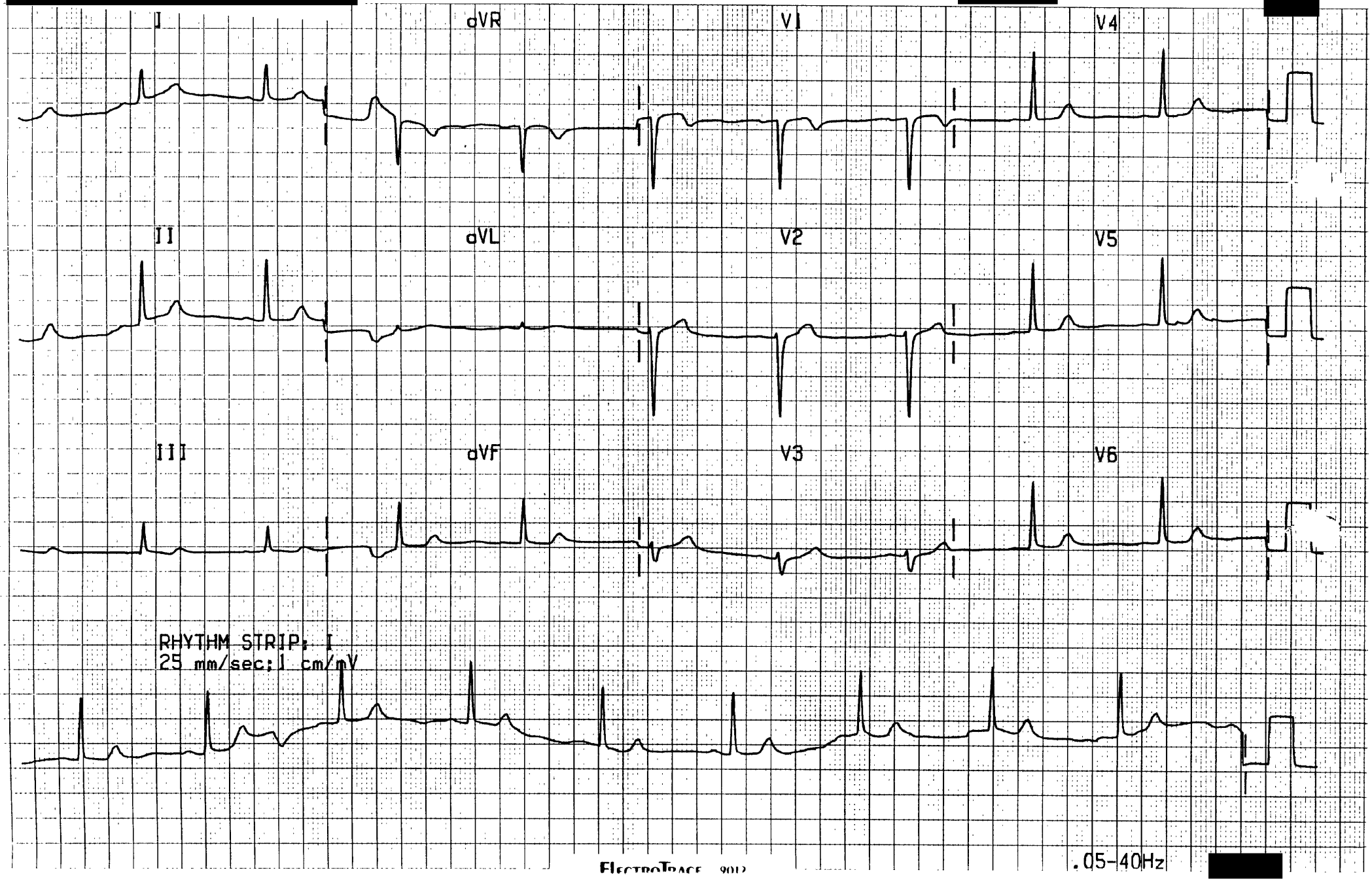
Reviewed by: [redacted] Date: 1-23-93

[redacted]

000049

49yo w/F

[redacted]



[redacted]

[redacted]

RADIOLOGY EXAMINATION

Patient Name: [redacted]
Date of Exam:
Requesting Ph[redacted]

MedRec#: [redacted]
Page: 1 of 1

MAMMOGRAPHY, 1-21-94:

MODERATELY DENSE BREASTS

Routine views of both breasts demonstrate moderately dense breast tissue bilaterally. There is general symmetry in the distribution of the parenchymal elements in the two breasts. No discrete mass or suspicious secondary finding is identified in either breast, and the skin and nipples appear normal.

IMPRESSION: NO MAMMOGRAPHIC EVIDENCE OF MALIGNANCY.

[redacted]

[redacted]

Dictated: 01/21/94
Transcribed: 01/21/94

[redacted]

[redacted]

Reviewed

========== ACTION TAKEN ==========

Patient informed by: [ ] Mail [ ] Phone [ ] office Visit

Results were: [N] Normal [A] Stable [ ] Recheck in ___ months

[ ] Other _____

000050

Referring Physician: _____ [redacted] Date: 1-31-94

[redacted]

Name: [redacted]
MedRec#:
Physician:
Location:
Specimen#:

Collected: 3/24/94
Received: 3/24/94
Reported: 3/30/94
Reviewed:
Status: FINAL

Age: 50 Sex: FEMALE
Data: ROUTINE

Test Name		Result	Reference Values		Units
HEMOGRAM					
01	WBC	4.80	4.00	10.80	THOUSAND
02	RBC	4.33	3.80	5.40	MILLION
03	HEMOGLOBIN	13.20	12.00	16.00	GM/DL
04	HEMATOCRIT	37.70	36.00	47.00	PERCENT
05	MCV	87.00	83.00	101.00	U3
06	MCH	30.50	27.00	33.00	U UG
07	MCHC	35.10	32.00	36.00	PERCENT
08	RDW	11.90	6.50	16.00	
09	PLATELET COUNT	199.00	150.00	450.00	THOUSAND
10	PLATELET MORPHOLOGY	Large Platelets			
DIFFERENTIAL					
01	NEUTROPHILS	63.90	40.00	80.00	PERCENT
02	LYMPHOCYTE	28.40	20.00	45.00	PERCENT
03	MONOCYTE	5.90	0.00-	10.00	PERCENT
04	EOSINOPHIL	1.30	0.00-	5.00	PERCENT
05	BASOPHIL	0.50	0.00-	5.00	PERCENT
08	RBC MORPH	NORMAL	NORMAL		
HDL/CORONARY FACTOR					
01	HDL	70.00	35.00	85.00	MG/DL
02	CHOLESTEROL	H 241.00	120.00	200.00	MG/DL
03	TRIGLYCERIDES	66.00	30.00	190.00	MG/DL
05	CORONARY RISK FACTOR	3.40	0.00-	4.40	RATIO

MEN	WOMEN	RISK FACTOR
3.4	3.3	1/2 AVERAGE RISK
5.0	4.4	AVERAGE RISK
9.6	7.1	2X AVERAGE RISK
24.0	11.0	3X AVERAGE RISK

HDL AND LDL NOT VALID IF TRIGLYCERIDE IS GREATER THAN OR EQUAL TO 400 MG/DL.

LDL					
[redacted]	LDL	H 158.00	104.00	130.00	MG/DL

ACTION TAKEN

Patient Informed by: [✓] Mail [ ] Phone [ ] Office visit
Results Were: [✓] Normal [ ] Stable [ ] Recheck in ___ months

[ ] Other _____

Reviewed by: [redacted] Date: 4-4-94

000051

[redacted]

Name: [redacted]
MedRec#:
Physician:
Location:

Specimen#:

Age: 50 Sex: FEMALE
Data: ROUTINE

Collected: 3/24/94
Received: 3/24/94
Reported: 3/30/94
Reviewed:
Status: FINAL

Test	Name		Result	Reference Values		Units
01	GLUCOSE		71.00	70.00	125.00	MG/DL
02	URIC ACID		4.20	2.20	7.70	MG/DL
03	CALCIUM		10.10	8.50	11.00	MG/DL
04	PHOSPHORUS, SERUM		4.50	2.50	4.70	MG/DL
05	CHOLESTEROL, TOTAL	H	241.00	120.00	200.00	MG/DL
06	TRIGLYCERIDES		66.00	30.00	190.00	MG/DL
07	TOTAL PROTEIN		7.40	6.00	8.50	GM/DL
08	ALBUMIN		4.30	3.00	5.50	GM/DL
09	TOTAL GLOBULIN		3.10	1.30	4.20	GM/DL
10	A/G RATIO		1.40	0.70	4.30	
11	BUN		11.00	7.00	26.00	MG/DL
12	CREATININE, SERUM		0.70	0.60	1.50	MG/DL
13	BUN/CREATININE RATIO		15.70	0.00-	0.00	
14	SODIUM, SERUM		142.00	136.00	149.00	MEQ/L
15	POTASSIUM, SERUM		4.80	3.50	5.20	MEQ/L
16	CHLORIDE, SERUM		101.00	96.00	110.00	MEQ/L
17	ALKALINE PHOSPHATASE		40.00	30.00	140.00	U/L
18	BILIRUBIN, TOTAL		0.90	0.20	1.50	MG/DL
19	SGOT		34.00	0.00-	50.00	U/L
20	SGPT		26.00	0.00-	55.00	U/L
21	GGT		11.00	4.00	63.00	U/L
22	IONIZED CALCIUM		4.56	4.00	6.00	MG/DL
23	OSMOLALITY		292.00	266.00	326.00	MOSM/KG

*CHOLESTEROL RECOMMENDATIONS:
NORMAL: LESS THAN 200 MG/DL
BORDERLINE: 200-239 MG/DL
ELEVATED: GREATER THAN 240 MG/DL

[redacted]

SEE REVERSE SIDE [redacted] PAGE 2

PATIENT NAME				PATIENT ID
[redacted]				[redacted]
ACCESSION NO.	AGE	SEX	TV/SOURCE	DATE RECEIVED
[redacted]	50	F		03/24/94
REFERRING PHYSICIAN		CLIENT NO.		DATE REPORTED
[redacted]		[redacted]		03/25/94
ORDER STATUS	COLLECTION DATE/TIME			CLIENT DATA
COMPLETE	03/24/94 10:00 AM			ROUTINE

TEST	OUTSIDE RANGE	WITHIN RANGE	UNITS	REFERENCE RANGE *
HDL/CORONARY FACTOR		(Continued)		
		MEN WOMEN RISK FACTOR		
		3.4 3.3 1/2 AVERAGE RISK		
		5.0 4.4 AVERAGE RISK		
		9.6 7.1 2X AVERAGE RISK		
		24.0 11.0 3X AVERAGE RISK		
		HDL AND LDL NOT VALID IF TRIGLYCERIDE IS GREATER THAN OR EQUAL TO 400 MG/DL.		
HEMOGRAM				
WBC		4.8	THOUSAND	4.0-10.8
RBC		4.33	MILLION	3.80-5.40
HEMOGLOBIN		13.2	GM/DL	12.0-16.0
HEMATOCRIT		37.7	PERCENT	36.0-47.0
MCV		87	U3	83-101
MCH		30.5	U UG	27.0-33.0
MCHC		35.1	PERCENT	32.0-36.0
RDW		11.9		6.5-16.0
PLATELET COUNT		199	THOUSAND	150-450
PLATELET MORPHOLOGY		Large Platelets		
DIFFERENTIAL				
NEUTROPHILS		63.9	PERCENT	40.0-80.0
LYMPHOCYTE		28.4	PERCENT	20.0-45.0
MONOCYTE		5.9	PERCENT	0.0-10.0
EOSINOPHIL		1.3	PERCENT	0.0-5.0
BASOPHIL		0.5	PERCENT	0.0-5.0
RBC MORPH		NORMAL		NORMAL

000053

[redacted]

SEE REVERSE SID [redacted] PAGE 1

[redacted]			PATIENT ID [redacted]
ACCESSION NO [redacted]	AGE 50	SEX F	TV/SOURCE	DATE RECEIVED 03/24/94
REFERRING PHYSICIAN [redacted]		CLIENT NO [redacted]	DATE REPORTED 03/25/94
ORDER STATUS COMPLETE	COLLECTION DATE/TIME 03/24/94 10:00 AM	CLIENT DATA ROUTINE	

TEST	OUTSIDE RANGE	WITHIN RANGE	UNITS	REFERENCE RANGE
[redacted] CHEMISTRY PROF				
GLUCOSE		71	MG/DL	70-125
URIC ACID		4.2	MG/DL	2.2-7.7
CALCIUM		10.1	MG/DL	8.5-11.0
PHOSPHORUS, SERUM		4.5	MG/DL	2.5-4.7
CHOLESTEROL, TOTAL	241 H		MG/DL	120-200
TRIGLYCERIDES		66	MG/DL	30-190
TOTAL PROTEIN		7.4	GM/DL	6.0-8.5
ALBUMIN		4.3	GM/DL	3.0-5.5
TOTAL GLOBULIN		3.1	GM/DL	1.3-4.2
A/G RATIO		1.4		0.7-4.3
BUN		11	MG/DL	7-26
CREATININE, SERUM		0.7	MG/DL	0.6-1.5
BUN/CREATININE RATIO		15.7		
SODIUM, SERUM		142	MEQ/L	136-149
POTASSIUM, SERUM		4.8	MEQ/L	3.5-5.2
CHLORIDE, SERUM		101	MEQ/L	96-110
ALKALINE PHOSPHATASE		40	U/L	30-140
BILIRUBIN, TOTAL		0.9	MG/DL	0.2-1.5
SGOT		34	U/L	0-50
SGPT		26	U/L	0-55
GGT		11	U/L	4-63
CALCULATED IONIZED CA		4.56	MG/DL	4.00-6.00
OSMOLALITY		292	MOSM/KG	266-326

*CHOLESTEROL RECOMMENDATIONS:
NORMAL: LESS THAN 200 MG/DL
BORDERLINE: 200-239 MG/DL
ELEVATED: GREATER THAN 240 MG/DL

Please note, effective April 2, 1994, new reference range for serum calcium is 8.5-10.5 mg/dl.

LDL				
LDL	158 H		MG/DL	104-130
HDL/CORONARY FACTOR				
HDL		70	MG/DL	35-85
CHOLESTEROL	241 H		MG/DL	120-200
TRIGLYCERIDES		66	MG/DL	30-190
CORONARY RISK FACTOR		3.4	RATIO	0.0-4.4

(Continued on Next Page)

[redacted]

000054

[redacted] NOV 15 1994

Name: [redacted]
MedRec#:
Physician:
Location:

Collected: 11/11/94
Received: 11/11/94
Reported: 11/14/94
Printed: 11/14/94 19:09

Age: 51 Sex: FEMALE
Specimen#: [redacted] Data:
Status: FINAL

Test Name	Result	Reference Values	Units

CYTOPATH, GYN SMEAR (1)
EPITHELIAL CELL MIX:
SQUAMOUS CELLS ONLY - HYSTERECTOMY
SOURCE VAGINA
ADEQUACY OF SPECIMEN:
SATISFACTORY
GENERAL CATEGORY:
NORMAL SMEAR
NARRATIVE DESCRIPTION:
WITHIN NORMAL LIMITS
HORMONAL EVALUATION:
CONSISTENT WITH AGE AND/OR HISTORY
TEST PERFORMED AT: [redacted]

THE PAP SMEAR IS A SCREENING TECHNIQUE TO AID IN THE DETECTION OF CERVICAL/ UTERINE CANCER AND CANCER PRECURSORS. IT IS NOT A DIAGNOSTIC PROCEDURE. BOTH FALSE-POSITIVE AND FALSE-NEGATIVE RESULTS HAVE BEEN EXPERIENCED WITH PAP SMEARS. ACCORDINGLY, ANY LESION SHOULD BE BIOPSIED UNLESS NOT INDICATED CLINICALLY. THE PAP SMEAR SHOULD NOT BE USED AS A SOLE MEANS TO DIAGNOSE OR EXCLUDE MALIGNANT AND PRE-MALIGNANT LESIONS. IT IS A SCREENING PROCEDURE ONLY.
CYTOTECHNOLOGIST: [redacted]

ACTION TAKEN

Patient Informed by: [X] Mail [ ] Phone [ ] Office visit
Results Were: [X] Normal [ ] Stable [X] Recheck in 12 months
[ ] Abnormal
[ ] Other
Reviewed by: [redacted] Date: 11/16/94

000055

[redacted]

'95 MAR -2 A11:25

Name: [redacted]
MedRec#:
Physician:
Location:

Collected: 2/27/95
Received: 2/27/95
Reported: 2/28/95
Printed: 3/01/95 15:35

Age: 51 Sex: FEMALE
Specimen#: [redacted] Data:
Status: FINAL

Test Name	Result	Reference Values	Units
CBC, PLATELET CT & DIFF			
TOTAL WBC	5.1	3.8 - 10.8	
RBC COUNT	4.72	3.9 - 5.2	MILL/MCL
HEMOGLOBIN	13.7	12 - 15.6	G/DL
HEMATOCRIT	40.5	35 - 46	%
MCV	85.8	80 - 100	FL
MCH	29.1	27 - 33	PG
MCHC	33.9	32 - 36	%
PLATELET COUNT	229	130 - 400	THOUS/MC
NEUTROPHIL	60.8		%
LYMPHOCYTE	29.5		%
MONOCYTE	7.4		%
ABSOLUTE MONOCYTE	377	200 - 1100	CELLS/MC
EOSINOPHIL	1.3		%
BASOPHIL	1		%
ABSOLUTE NEUTROPHIL	3101	1500 - 7800	CELLS/MC
ABSOLUTE EOSINOPHIL	66	50 - 550	CELLS/MC
ABSOLUTE BASOPHIL	51	0 - 200	CELLS/MC
ABSOLUTE LYMPHOCYTE	1505	850 - 4100	CELLS/MC
THYROID STIMULATING HORMONE,	3.7	0.4 - 5.5	MCIU/ML
CHEM PANEL PLUS			
CARBON DIOXIDE			
CARBON DIOXIDE	24	20 - 32	MEQ/L
GLUCOSE	88	70 - 125	
UREA NITROGEN (BUN)	11	7 - 25	MG/DL
BUN/CREATININE RATIO	13.8	6 - 25	RATIO (C
CREATININE	0.8	0.7 - 1.4	MG/DL
SODIUM	143	135 - 146	MEQ/L
POTASSIUM	5.2	3.5 - 5.3	MEQ/L
CHLORIDE	103	95 - 108	MEQ/L
CALCIUM	9.9	8.5 - 10.3	MG/DL

ACTION TAKEN

Patient Informed by: [X] Mail [ ] Phone [ ] Office visit
Results Were: [ ] Normal [ ] Stable [ ] Recheck in ___ months
[ ] Abnormal [redacted]
[ ] Other _____
Reviewed by: [redacted] 2-28-95

000056

[redacted]

'95 MAR -2 A11:25

Name: [redacted]
MedRec#:
Physician:
Location:

Collected: 2/27/95
Received: 2/27/95
Reported: 2/28/95
Printed: 3/01/95 15:35

Age: 51 Sex: FEMALE

Specimen#: [redacted] Data:

Status: FINAL

Test Name		Result	Reference Values	Units
PHOSPHORUS, INORGANIC		3.9	2.5 - 4.5	MG/DL
ALBUMIN		4.6	3.2 - 5	G/DL
BILIRUBIN TOTAL		1.1	0 - 1.3	MG/DL
BILIRUBIN DIRECT		0.3	0 - 0.4	MG/DL
BILIRUBIN, INDIRECT		0.8	0 - 1.3	MG/DL (C
PROTEIN TOTAL		7.6	6 - 8.5	G/DL
ALKALINE PHOSPHATASE		41	20 - 125	U/L
GGTP		10	0 - 45	U/L
AST (SGOT)		16	0 - 42	U/L
ALT (SGPT)		14	0 - 48	U/L
URIC ACID		4.1	2.5 - 7.5	MG/DL
IRON		96	25 - 170	MCG/DL
TRIGLYCERIDES		70	<200	MG/DL
CHOLESTEROL, TOTAL	H	270	<200	MG/DL
GLOBULIN		3	2.2 - 4.2	G/DL
LACTATE DEHYDROGENASE		105	0 - 250	U/L
ALBUMIN/GLOBULIN RATIO		1.5	0.8 - 2	RATIO (C
HDL-CHOLESTEROL		58	35 OR GREATER	MG/DL
LDL-CHOLESTEROL	H	198	0 - 130	MG/DL (C
CHOL/HDL-CHOL RATIO	H	4.7	<4.45	RATIO (C

[redacted]

RADIOLOGY EXAMINATION

Patient Name: [redacted]
Date of Exam: 02/27/95
Requesting Physician: [redacted] MD

MedRec#: [redacted]
Page: 1 of 1

CLINICAL HISTORY: ROUTINE.

MAMMOGRAM: 02-27-95.

Craniocaudal and oblique views of both breasts are obtained utilizing low dose--film screen technique. Comparison is made to the previous examination dated 01-21-94.

The breasts are moderately dense with symmetrical distribution of parenchyma. There is no evidence of any suspicious tumor masses, tumor-type calcifications, skin thickening or retraction noted in either breast.

CONCLUSION:

1. NO SIGNIFICANT INTERVAL CHANGE IS NOTED FROM THE PREVIOUS EXAMINATION DATED 01-21-94.

2. THERE IS NO MAMMOGRAPHIC EVIDENCE OF MALIGNANCY.

3. GOOD SELF-BREAST EXAMINATIONS AND YEARLY ROUTINE MAMMOGRAMS ARE SUGGESTED.

[redacted]

[redacted]

Dictated: 02/28/95
Transcribed: 03/01/95
[redacted]

Reviewed

========== ACTION TAKEN ==========

Patient informed by: [X] Mail [ ] Phone [ ] Office Visit

Results were: [X] Normal [ ] Stable [ ] Recheck in ___ months

[ ] Other _____

Referring Physic[redacted] Date: 3/6/95

000058

[redacted]

RADIOLOGY EXAMINATION

Patient Name: [redacted]
Date of Exam: 03/14/95
Requesting Physician: _____

MedRec#: [redacted]
Page: 1 of 1

LEFT KNEE: 3-14-95.

Normal left knee.

[redacted]

[redacted]

Dictated:
Transcribed

_____
Reviewed

========== ACTION TAKEN ==========

Patient informed by: [ ] Mail [ ] Phone [ ] Office Visit

Results were: [ ] Normal [ ] Stable [ ] Recheck in ___ months

[ ] Other _____

000059

Referring Physician: _____ Date: _____

[redacted]

'95 AUG 30 A8:51

PATIENT NAME: [redacted]
PATIENT ID : [redacted]
SEX: F AGE: 52 DOB:
VOLUME :
SOURCE :
FASTING : Y

ACCESSION : [redacted]
REQUISITION:

COLLECTED : 29-AUG-95
RECEIVED : 29-AUG-95
DATE FINAL :

CLIENT NAME : [redacted]

CLIENT NO. : [redacted]

PHYSICIAN : [redacted]

COMMENTS :

TEST REQUEST: LIPID SCREEN

TEST NAME	RESULT		UNITS	REFERENCE RANGE
LIPID SCREEN:				
CHOLESTEROL	233		MG/DL	100-240
TRIGLYCERIDES	85		MG/DL	30-150
TOTAL CHOL/HDL RATIO	3.2			
HDL	73		MG/DL	40-90
LDL (CALCULATED)	143	HIGH	MG/DL	70-130

LDL	mg/dL	CHOLESTEROL
<130	Desirable	<200
130-159	Borderline	200-239
>159	High Risk	>239

[redacted]

000060

[redacted]

[redacted]

[redacted]

COLLECTED : 08-APR-96
RECEIVED : 09-APR-96
DATE FINAL : 10-APR-96

CLIENT NO. : [redacted]

COMMENTS :

ST REQUEST: PAP SMEAR

ST NAME	RESULT	UNITS	REFERENCE RANGE

CYTOLOGY REPORT

***** CLINICAL INFORMATION *****

P DATE: [redacted] PREVIOUS SMEAR:
URCE: /
TIENT HISTORY: HYST;HORMONE THEARPY
/SICIANS DIAGNOSIS:

***** CYTOLOGY RESULTS *****

AP SMEAR:
SPECIMEN ADEQUACY:
SATISFACTORY for evaluation.
GEN. CATEGORIZATION:
WITHIN NORMAL LIMITS
HORMONAL STATUS:
Moderate estrogen effect.

[redacted]

[redacted]

[redacted]

[redacted]

000061

[redacted]

'96 MAR 15 AM 10:06

PATIENT NAME: [redacted]
PATIENT ID : [redacted]
SEX: F AGE: 32 DOB:
VOLUME :
SOURCE :
TESTING :

ACCESSION :
REQUISITION: [redacted]
COLLECTED : 08-MAR-96
RECEIVED : 12-MAR-96
DATE FINAL : 12-MAR-96

CLIENT NAME : [redacted]
CLIENT AC. : [redacted]

PHYSICIAN : [redacted]
COMMENTS :

LAST REQUEST: URINALYSIS

TEST NAME	RESULT	UNITS	REFERENCE RANGE
URINALYSIS:			
COLOR	YEL		yellow
APPEARANCE	CLOUDY		clear
GLUCOSE,URINE	NEG		negative
BILIRUBIN,URINE	NEG		negative
KETONES,URINE	NEG		negative
SPECIFIC GRAVITY,URINE	1.010		1.003-1.035
BLOOD,URINE	SMALL		negative
PH,URINE	8.0		4.6-8.0
PROTEIN,URINE	NEG		negative
UROBILINOGEN	NORMAL		0.2-1.0
NITRITE,URINE	NEG		negative
LEUK. ESTERASE	MOD		negative
RBC/HPF,URINE	8-10		0-2
WBC/HPF,URINE	15-20		0-3
EPI CELLS,URINE	10-12		0-5
BACTERIA,URINE	2+		negative
YEAST/TRICH			negative

TEST(S) PERFORMED BY: [redacted]

[redacted]

000062

[redacted]

'96 APR 22 A8:16

PATIENT NAME: [redacted]
PATIENT ID : [redacted]
M/F AGE: 32 DOB:
ROOM :
BASE :
STAT :

ACCESSION : [redacted]
REQUISITION: [redacted]

COLLECTED : 19-APR-96
RECEIVED : 19-APR-96
DATE FINAL : 20-APR-96

CLIENT NAME : [redacted]

CLIENT NO. : [redacted]

PHYSICIAN : [redacted]

COMMENTS : DR. [redacted]

TEST REQUEST: URINALYSIS - ROUTINE

TEST NAME	RESULT	UNITS	REFERENCE RANGE
URINALYSIS - ROUTINE:			
COLOR	YEL		Yellow
APPEARANCE, URINE	CLEAR		Clear
SPECIFIC GRAVITY	1.020		1.003-1.033
PH	6.5		5-8 PH
PROTEIN, URINE	NEG		negative
GLUCOSE, URINE	NEG		negative
KETONES, URINE	NEG		negative
BLOOD, URINE	NEG		negative
LEUK. ESTERASE	NEG		negative
NITRITE	NEG		negative
BILIRUBIN, URINE	NEG		negative
UROBILINOGEN SCREEN	NOR		normal

[redacted]

[redacted]

RADIOLOGY EXAMINATION

Patient Name: [redacted]
Date of Exam: 07/02/96
Requesting Physician: _____

MedRec#: [redacted]
Page: 1 of 1

BILATERAL MAMMOGRAPHY: 07-02-96.

MODERATELY DENSE BREASTS

Routine views of both breasts demonstrate moderately dense breast tissue bilaterally. There is general symmetry in the distribution of the parenchymal elements in the two breasts. No discrete mass or suspicious secondary finding is identified in either breast, and the skin and nipples appear normal.

Comparison is made to the prior bilateral mammogram study performed on 02-27-95; there is essentially no interval change since the prior mammogram exam.

IMPRESSION:

1. NO MAMMOGRAPHIC EVIDENCE OF MALIGNANCY.

2. WOULD NOW URGE OBTAINING ADDITIONAL COMPARATIVE BILATERAL MAMMOGRAPHY IN ONE YEAR.

[redacted]

[redacted]
Dictated:
Transcribed:
[redacted]

[redacted]

========== ACTION TAKEN ==========

Patient informed by: [X] Mail [ ] Phone [X] Office Visit

Results were: [X] Normal [ ] Stable [ ] Recheck in [redacted] months

[ ] Other _____ [redacted]

[redacted]

Referring Physician: _____ Date: 7-7-96

000064

[redacted]

RADIOLOGY EXAMINATION

Patient Name: [redacted]
Date of Exam: 08/01/97
Requesting Physician: [redacted]

MedRec#: [redacted]
Page: 1 of 1

PA AND LATERAL CHEST: AUGUST 1, 1997.

FINDINGS:

Two views of the thorax are submitted for evaluation. No comparison radiographs are available.

Vague patchy density overlies the lateral segment of the right middle lobe on both views. Additionally, patchy radiopacity overlies the lateral aspect of the right upper lobe and lateral aspect of the left lower lobe on the PA radiograph. A marked thoracic spine curvature is seen associated with minimal degenerative changes. The examination is otherwise unremarkable.

IMPRESSION:

1. RIGHT MIDDLE LOBE PNEUMONIA.

2. OTHER VAGUE PATCHY DENSITIES AS DESCRIBED ABOVE. CONTINUED RADIOGRAPHIC FOLLOW-UP IS RECOMMENDED TO COMPLETE RESOLUTION. DISTANT RADIOGRAPHS WOULD BE VERY HELPFUL FOR COMPARISON IF THEY CAN BE MADE AVAILABLE.

[redacted]

[redacted]
Dictated: 08/04/97
Transcribed: 08/05/97
[redacted]

[redacted]
Reviewed

========== ACTION TAKEN ==========
Patient informed by: [ ] Mail [ ] Phone [X] Office Visit

Results were: [ ] Normal [ ] Stable [ ] Recheck in ___ months

[ ] Other pneumonia

Referring Physician: [redacted] Date: [redacted]

000065

[redacted]

RADIOLOGY EXAMINATION

Patient Name: [redacted]
Date of Exam: 08/03/97
Requesting Physician: [redacted] MD

MedRec#: [redacted]
Page: 1 of 1

PA AND LATERAL CHEST: August 3, 1997.

FINDINGS:

Two views of the thorax are submitted for evaluation and compared with the August 1, 1997 study. No significant change is seen. Please refer to the August 1 interpretation for full evaluation.

[redacted]

[redacted]

[redacted]

Dictated: 08/04/97
Transcribed: 08/05/97

[redacted]

Reviewed

========== ACTION TAKEN ==========

Patient informed by: [ ] Mail [ ] Phone [ ] Office Visit

Results were: [ ] Normal [ ] Stable [ ] Recheck in ___ months

[ ] Other _____

_____

Referring Physician: _____ [redacted] _____ Date: _____

[redacted]

PATIENT NAME: [redacted]
PATIENT ID : [redacted]
SEX: F AGE: 54 DOB: [redacted]
VOLUME :
SOURCE :
FASTING :

ACCESSION : [redacted]
REQUISITION: [redacted]
COLLECTED : 03-AUG-97
RECEIVED : 04-AUG-97
DATE FINAL : 04-AUG-97

CLIENT NAME : [redacted]
CLIENT NO. : [redacted]

PHYSICIAN : [redacted]
COMMENTS :

TEST REQUEST: AUTO. CHEM. PANEL.

TEST NAME	RESULT		UNITS	REFERENCE RANGE
CHEMISTRIES:				
GLUCOSE	90		MG/DL	65-115
BUN	13		MG/DL	5-26
CREATINE	0.9		MG/DL	0.6-1.5
SODIUM	146		MEQ/L	135-147
POTASSIUM	4.8		MEQ/L	3.5-5.3
CHLORIDE	104		MEQ/L	96-109
AUTO CHEM PANEL:				
CALCIUM	9.5		MG/DL	8.5-10.6
PHOSPHORUS	4.2		MG/DL	2.5-4.5
URIC ACID	2.4		MG/DL	2.2-7.7
PROTEIN, TOTAL	7.4		G/DL	6.0-8.5
GLOBULIN	3.6			2.2-4.1
ALBUMIN	3.8		G/DL	3.5-5.5
A/G RATIO	1.1			0.9-2.0
TOTAL BILIRUBIN	0.4		MG/DL	0.1-1.2
ALK. PHOS.	68		U/L	25-150
AST (SGOT)	17		U/L	0-45
ALT (SGPT)	27		U/L	0-50
GGTP	28		U/L	0-70
LDH	146		U/L	0-240
LIPIDS:				
CHOLESTEROL		214 H	MG/DL	100-199
TRIGLYCERIDES	96		MG/DL	10-199
IRON:				
IRON	67		UG/DL	35-175

Rec'd 8.7.97

[redacted]

[redacted]

PAGE 1 F [redacted] 04-AUG-97

000067

[redacted]

PATIENT NAME: [redacted]
PATIENT ID : [redacted]
SEX: F AGE: 54 DOB: [redacted]
VOLUME :
SOURCE :
TASTING :

ACCESSION : [redacted]
REQUISITION:

COLLECTED : 05-AUG-97
RECEIVED : 06-AUG-97
DATE FINAL : 07-AUG-97

CLIENT NAME : [redacted]

CLIENT NO. : [redacted]

PHYSICIAN : [redacted]

COMMENTS :

TEST REQUEST: LEGIONELLA PNEUMOPHILA AB.

TEST NAME	RESULT	UNITS	REFERENCE RANGE
LEGIONELLA PNEUMOPHILA AB:			
LEGIONELLA TOT AB,QN			
. Pneumophila S1-6	1:64		
. Longbeachae S1,2	1:64		
Atypic Legionella	1:64		

[redacted]

)or=1:64 is presumptive evidence of previous infection.
)or=1:256 may suggest current infection, with symptoms.

[redacted]

[redacted]

[redacted]

[redacted]

000068

[redacted]

[redacted]

TIENT [redacted]
TIENT [redacted]
X: F AGE: 54 DOB: [redacted]
LUME :
URCE :
STING :

ACCESSION : [redacted]
REQUISITION:

COLLECTED : 05-AUG-97
RECEIVED : 06-AUG-97
DATE FINAL : 07-AUG-97

IENT NAME : [redacted]

CLIENT NO. : [redacted]

YSICIAN : [redacted]

COMMENTS :

ST REQUEST: LEGIONELLA PNEUMOPHILA AB.

ST NAME	RESULT	UNITS	REFERENCE RANGE
LEGIONELLA PNEUMOPHILA AB:			
GIONELLA TOT AB,QN			
Pneumophila S1-6	1:64		
Longbeachae S1,2	1:64		
ypic Legionella	1:64		

[redacted]

>or=1:64 is presumptive evidence of previous infection.
>or=1:256 may suggest current infection, with symptoms.

[redacted]

[redacted]

[redacted]

[redacted]

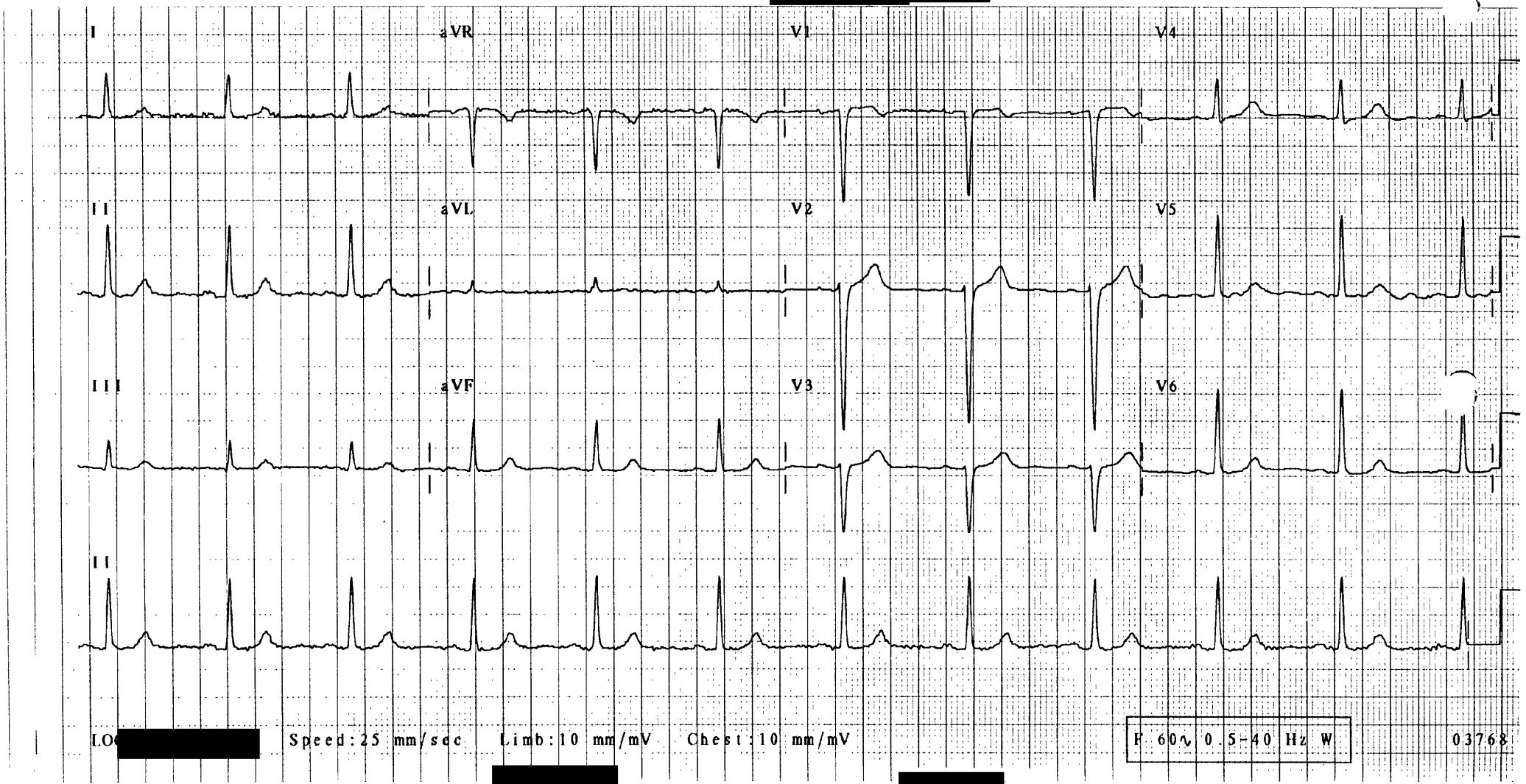
000069

08/14/1997 09:08:49 AM [redacted]

Oper: [redacted]

000070

[redacted]



[redacted]

[redacted]

PATIENT NAME: [redacted]
PATIENT ID : [redacted]
SEX: F AGE: 54 DOB: [redacted]
VOLUME :
SOURCE : URINE
FASTING :

ACCESSION : [redacted]
REQUISITION: [redacted]

COLLECTED : 14-AUG-97
RECEIVED : 14-AUG-97
DATE FINAL : 18-AUG-97

CLIENT NAME : [redacted]

CLIENT NO. : [redacted]

PHYSICIAN : [redacted]

COMMENTS :

TEST REQUEST: TSH, URINALYSIS - ROUTINE,
CBC WITH PLATELET COUNT,
ACP(W/O GGTP,IRON,LDH)...

TEST NAME	RESULT		UNITS	REFERENCE RANGE
CHEMISTRIES:				
GLUCOSE	91		MG/DL	65-115
BUN	12		MG/DL	5-26
CREATININE	0.7		MG/DL	0.6-1.5
SODIUM	142		MEQ/L	135-147
POTASSIUM	5.2		MEQ/L	3.5-5.3
CHLORIDE	101		MEQ/L	96-109
AUTO CHEM PANEL:				
CALCIUM	9.9		MG/DL	8.5-10.6
PHOSPHORUS	4.2		MG/DL	2.5-4.5
URIC ACID	2.2		MG/DL	2.2-7.7
PROTEIN, TOTAL	7.9		G/DL	6.0-8.5
GLOBULIN	3.6			2.2-4.1
ALBUMIN	4.3		G/DL	3.5-5.5
A/G RATIO	1.2			0.9-2.0
TOTAL BILIRUBIN	0.5		MG/DL	0.1-1.2
ALK. PHOS.	61		U/L	25-150
AST (SGOT)	30		U/L	0-45
ALT (SGPT)	29		U/L	0-50
LIPIDS:				
CHOLESTEROL		231 H	MG/DL	100-199
TRIGLYCERIDES		279 H	MG/DL	10-199
THYROID FUNCTION:				
TSH	2.8		uIU/ML	0.35-5.50
HEMATOLOGY:				
WBC	6.7		THOU/MM3	4.0-10.5
RBC	4.39		MILL/MM3	3.80-5.10
HGB	13.1		G/DL	11.5-15.0
HCT	40.1		%	34-44

[redacted]

97 AUG 18 P1:28

000071

[redacted]

PATIENT NAME: [redacted]
PATIENT ID : [redacted]
SEX: F AGE: 54 DOB: [redacted]
VOLUME :
SOURCE : URINE
FASTING :

ACCESSION : [redacted]
REQUISITION: [redacted]

COLLECTED : 14-AUG-97
RECEIVED : 14-AUG-97
DATE FINAL : 18-AUG-97

CLIENT NAME : [redacted]

CLIENT NO. : [redacted]

PHYSICIAN : [redacted]

COMMENTS :

TEST REQUEST: TSH, URINALYSIS - ROUTINE,
CBC WITH PLATELET COUNT,
ACP(W/O GGTP,IRON,LDH)...

TEST NAME	RESULT	UNITS	REFERENCE RANGE
HEMATOLOGY: (Continued).			
MCV	91	FL	80-98
MCH	29.8	UUG	27.0-34.0
MCHC	32.6	G/DL	32.0-36.0
PLATELETS	288	THOU/MM3	140-415
NEUT	68	%	40-74
LYMPH	26	%	14-46
MONO	5	%	4-13
EOS	1	%	0-7
BASO	0	%	0-3
RDW	12.4		11.7-15.0
URINALYSIS:			
COLOR	YELLO		Yellow
APPEARANCE, URINE	CLEAR		CLEAR
SPECIFIC GRAVITY	1.005		1.003-1.035
PH	7.0		5-8 PH
PROTEIN, URINE	NEG		Negative
GLUCOSE, URINE	NEG		Negative
KETONES, URINE	NEG		Negative
BLOOD, URINE	NEG		Negative
LEUK. ESTERASE	NEG		Negative
NITRITE	NEG		Negative
BILIRUBIN, URINE	NEG		Negative
UROBILINOGEN SCREEN	NORMAL		NORMAL=<1 mg/dl

LEGIONELLA AG, URINE:
LEGIONELLA URINARY AG. TEST NOT PERFORMED

QUANTITY NOT SUFFICIENT.

LEGIONELLA AB. IgM:		
L. PNEUMOPHILA (serotyp	<1:256	
LEGIONELLA SPECIES (non	<1:256	

[redacted]

000072

 CONTINUED...

[redacted]

PATIENT NAME: [redacted]
PATIENT ID :
SEX: F AGE: 54 DOB: [redacted]
VOLUME :
SOURCE : URINE
FASTING :

ACCESSION : [redacted]
REQUISITION:

COLLECTED : 14-AUG-97
RECEIVED : 14-AUG-97
DATE FINAL : 18-AUG-97

CLIENT NAME : [redacted]

CLIENT NO. : [redacted]

PHYSICIAN : [redacted]

COMMENTS :

TEST REQUEST: TSH, URINALYSIS - ROUTINE,
CBC WITH PLATELET COUNT,
ACP(W/O GGTP,IRON,LDH)...

TEST NAME	RESULT	UNITS	REFERENCE RANGE

LEGIONELLA AB. IgM: (Continued).
LEGIONELLA SPECIES (non: (Continued).

REFERENCE RANGE: <1:256

INTERPRETIVE CRITERIA:

<1:256 Antibody Not Detected
> or = 1:256 Antibody Detected

IgM antibody to L. pneumophila, serotypes 1-10 and to 10 species of non-pneumophila Legionella is measured using an IgM specific conjugate. We recommend that the IgM test always be performed in conjunction with the polyvalent antibody test.

The IgM response in legionellosis patients tends to develop concurrently with the IgG response and may remain elevated as long as the IgG response remains elevated. Therefore, the interpretation of IgM titers is the same as polyvalent Legionella titers. IgM values > or = 1:256 may indicate acute or recent infection. Crossreactions have been described with several species of bacteria and mycoplasma.

TEST PERFORMED BY: [redacted]

'97 AUG 18 P1:28

[redacted]

000073

[redacted]

PATIENT NAME: [redacted]
PATIENT ID : [redacted]
SEX: F AGE: 54 DOB: [redacted]
VOLUME :
SOURCE :
FASTING :

ACCESSION : [redacted]
REQUISITION: [redacted]
COLLECTED
RECEIVED
DATE FINAL

CLIENT NAME : [redacted]
CLIENT NO. [redacted]

PHYSICIAN : [redacted]

COMMENTS : [redacted] LEGIONELLA AG URINE

TEST REQUEST: LEGIONELLA AG, URINE.

TEST NAME	RESULT	UNITS	REFERENCE RANGE

LEGIONELLA AG, URINE:
LEGIONELLA URINE Ag FINAL REPORT [redacted]
NEGATIVE
NO LEGIONELLA PNEUMOPHILA URINE ANTIGEN DETECTED.

[redacted]

000074

[redacted]

PATIENT NAME: [redacted]
PATIENT ID : [redacted]
SEX: F AGE: 54 DOB: [redacted]
VOLUME :
SOURCE : STOOL
FASTING :

ACCESSION : [redacted]
REQUISITION: [redacted]

COLLECTED : 15-AUG-97
RECEIVED : 16-AUG-97
DATE FINAL : 18-AUG-97

CLIENT NAME : [redacted]

CLIENT NO. : [redacted]

PHYSICIAN : [redacted]

COMMENTS :

TEST REQUEST: CLOSTRIDIUM DIFFICLE TOXIN.

TEST NAME	RESULT	UNITS	REFERENCE RANGE
CLOSTRIDIUM DIFFICLE TOXIN:			
C. DIFFICILE TOXIN	NEGATIVE FOR CLOSTRIDIUM DIFFICILE		

[redacted]

'97 AUG 18 P1:21

000075

[redacted]

RADIOLOGY EXAMINATION

Patient Name: [redacted]
Date of Exam: 08/20/97
Requesting Physician: [redacted]

MedRec#: [redacted]
Page: 1 of 1

CLINICAL HISTORY: FOLLOW-UP PNEUMONIA.

CHEST, 8-20-97; COMPARISON 8-3-97:

Patchy infiltrates of right upper and lower lobes have been completely resolved on today's examination. Other chest findings are essentially unchanged. There is dextroscoliosis in the mid dorsal spine.

IMPRESSION: COMPLETELY RESOLVED RIGHT UPPER AND LOWER LOBE INFILTRATES.

[redacted]

[redacted]

Dictated: 08/21/97
Transcribed: 08/22/97

[redacted]

SEP 3 '97

[redacted] Reviewed

========== ACTION TAKEN ==========

Patient informed by: [ ] Mail [ ] Phone [X] office visit

Results were: [X] Normal [ ] Stable [ ] Recheck in ___ months

[ ] Other _____

000076

[redacted]

Referring Physician: _____ Date: [redacted]

[redacted]

RADIOLOGY EXAMINATION

Patient Name: [redacted]
Date of Exam: 10/09/97
Requesting Physician: [redacted]

MedRec#: [redacted]
Page: 1 of 1

SCREENING MAMMOGRAMS: 10-9-97.

Compared to previous study of one year earlier.

FINDINGS:

Craniocaudal and mediolateral oblique views are obtained on this fifty-four year old patient of Dr. [redacted] without current symptomatology. The patient is on Premarin hormone replacement for the last ten years.

The breasts remain quite dense. This is consistent with the hormone replacement therapy. No suspect calcifications are noted. No discrete masses are identified.

IMPRESSION:

1. BREASTS OF THIS DENSITY MAY READILY OBSCURE FINE CALCIFICATIONS AND MASSES. THEREFORE, SHOULD THE PATIENT HAVE ANY SIGNIFICANT SYMPTOMATOLOGY AND/OR PALPABLE MASS, THE RELATIVE LACK OF FINDINGS MAMMOGRAPHICALLY SHOULD NOT DETER FURTHER ASSESSMENT, FOR EXAMPLE BY SONOGRAPHY. [redacted]

2. IN THE ABSENCE OF INTERVENING CLINICAL FINDINGS, FOLLOW-UP IS SUGGESTED IN ONE YEAR. [redacted]

[redacted]

Dictated: 10/10/97
Transcribed: 10/12/97

[redacted]

OCT 16 '97

[redacted]

Reviewed

========== ACTION TAKEN ==========

Patient informed by: [ ] Mail [ ] Phone [ ] Office Visit

Results were: [X] Normal [ ] Stable [X] Recheck in 12 months

[ ] Other _____

000077

Referring Physician: [redacted] Date: 10-16-97

[redacted]

PATIENT NAME: [redacted]
PATIENT ID : [redacted]
SEX: F AGE: 54 DOB: [redacted]
VOLUME :
SOURCE :
FASTING :

ACCESSION : [redacted]
REQUISITION:

COLLECTED : 21-OCT-97
RECEIVED : 22-OCT-97
DATE FINAL : 29-OCT-97

'97 OCT 29

CLIENT NAME : [redacted]

CLIENT NO. : [redacted]

PHYSICIAN : [redacted]

COMMENTS :

TEST REQUEST: PAP SMEAR.

TEST NAME	RESULT	UNITS	REFERENCE RANGE

CYTOLOGY REPORT

***** CLINICAL INFORMATION *****

LMP DATE: 54 PREVIOUS SMEAR:
SOURCE: CUFF SMEAR
PATIENT HISTORY: Post-hysterectomy,WELL EXAM
PHYSICIANS DIAGNOSIS:

***** CYTOLOGY RESULTS *****

PAP SMEAR:
SPECIMEN ADEQUACY:
SATISFACTORY for evaluation.

GEN. CATEGORIZATION:

WITHIN NORMAL LIMITS

HORMONAL STATUS:
Moderate estrogen effect.

CYTOTECH:..... [redacted]

[redacted]

[redacted]

PATIENT NAME: [redacted]
PATIENT ID : [redacted]
SEX: F AGE: 54 DOB: [redacted]
VOLUME :
SOURCE :
FASTING :

ACCESSION : [redacted]
REQUISITION:

COLLECTED : 21-OCT-97
RECEIVED : 31-OCT-97
DATE FINAL : 04-NOV-97

CLIENT NAME : [redacted]

CLIENT NO. : [redacted]

PHYSICIAN : [redacted]

COMMENTS :

TEST REQUEST: OCCULT BLOOD.

TEST NAME	RESULT	UNITS	REFERENCE RANGE
OCCULT BLOOD:			
DAY ONE(1)	NEGATIVE		negative
TESTING PERFORMED BY:	[redacted]		

[redacted]

000079